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ABSTRACT

Plenary session papers from a workshop focusing on how the health professions might provide better care for victims of violence and prevent violence itself comprise this document. Papers include: (1) "Welcome and 'Charge' to the Participants" (C. Everett Koop); (2) "Interpersonal Violence and Public Health Care: New Directions, New Challenges" (Marvin E. Wolfgang); (3) "Violence and Public Health" (William H. Foege); (4) "Interpersonal Violence: A Comprehensive Model in a Hospital Setting--from Policy to Program" (Karil S. Klingbeil); (5) "Interdisciplinary Interventions Applicable to Prevention of Interpersonal Violence and Homicide in Black Youth" (Deborah Prothrow-Stith); and (6) "This Epidemic of Family Violence" (Anthony V. Bouza). Recommendations from the workshop's work groups on the topics of assault and homicide, child abuse, child sexual abuse, elder abuse, rape and sexual assault, and spouse abuse are included. Results of a Delphi survey on the roles of education and research in violence and medical, health, and social services delivery are presented. (ABL)

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Surgeon General's Workshop on Violence and Public Health

Report

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CG 020161

Leesburg, Virginia
October 27-29, 1985

Surgeon General's Workshop on Violence and Public Health

Report

Sponsors

U.S. Department of Health and Human Services: the Alcohol, Drug Abuse, and Mental Health Administration, Centers for Disease Control, Health Resources and Services Administration, and National Institutes of Health of the U.S. Public Health Service and the Administration on Children, Youth, and Families and the Administration on Developmental Disabilities of the Office of Human Development Services

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Plenary Session I

Welcome and "Charge" to the Participants

Presented by C. Everett Koop, MD
Surgeon General of the U.S. Public Health Service
Sunday evening, October 27, 1985

Let me personally thank you all for accepting my invitation and coming to this workshop. Before we end our work on Tuesday, I hope I will have been able to thank each of you in person.

I will be here throughout the workshop, and I hope to visit each work group once to catch at least the sense of your deliberations.

I have also assigned each member of my "Ad Hoc Planning and Advisory Committee" to a specific work group. I have asked each one to be helpful to the chair when needed and in other ways carry my personal interest to — and from — those important work sessions.

I will also rely on them to help me frame my response to the recommendations that are to be presented in the fourth plenary session on Tuesday afternoon.

Because they've been so important to the planning of this workshop over the past 13 months — and because they continue to be important to the way we proceed — I'd like to take a moment to introduce them to you in

alphabetical order: Ann Burgess, Ted Cron, Margo Gordon, Dave Heppel, Tom Lalley, Bob McGovern, Nikki Millor, David Nee, Eli Newberger, Delores Parron, Mark Rosenberg, Saleem Shah, and Alan Wurtzel.

If you're still wondering by what magic your name came to my attention, please be assured that it wasn't through magic at all but rather through the diligence of this committee reaching out into the larger community. They spent almost five months searching out the best possible people to come together to share what they know and what they see as the things still to be done.

Let me hasten to add that many excellent people are not here and their absence may be noted. First, it is possible that we *did* invite them, but they either had to decline or, after accepting, found they could not make it after all. Others did not receive an invitation for the time-worn but unsatisfactory reason of space: We asked Xerox for just so many spaces . . . 150 of them . . . a number we felt was the maximum for a workshop in which we hope everyone will contribute.

But I would be very disappointed if this were both the first and the last workshop on this subject. I am hoping that our experience here will be repeated in the coming months in every region of our country and that, as a result, many of the people who are missing from this workshop will have a chance to contribute in the future through those follow-up events.

I understand that such may well be possible in the southwest, thanks to the people here from Texas. And later this week, my staff will be talking with some people from the midwest about a follow-up meeting there.

But the prize for immediate follow-up ought to go to the nurses who are here. A contingent of the "Leesburg Nurses" will form a panel and present the recommendations of this workshop on Friday evening, at the opening session of the "First National Nursing Conference on Violence Against Women," being held November 1 through 3 at the University of Massachusetts at Amherst.

Congratulations . . . good for you.

For most of you, I'm sure this will not be your only conference on violence this year. Some of you will have attended several before the year has ended.

But I hope the Leesburg Workshop will be different in one major respect: Our focus will be squarely on how the health professions might provide better care for victims of violence and also how they might contribute to the prevention of violence.

It is clear that the medicine, nursing, psychology, and social service professions have been slow in developing a response to violence that is

integral to their daily professional life. As a result, we are not sure if the estimated 4 million victims of violence this year will receive the very best care possible.

Nor can we be sure that enough will be done to prevent violence from claiming 4 million or more victims again *next* year.

I think we all share these nagging suspicions. Fortunately, we also seem to share the same notions about what can be done about them and how we can do it.

That is one of the interesting outcomes of the "Delphi" survey that so many of you took part in over the summer. According to the final report, we generally agree on many ideas that lead directly to action.

Multidisciplinary Approach

One such idea is that the best approach the health professions can make to interpersonal violence is a multidisciplinary approach.

We know we have not been as successful as we would like to be in the care and treatment of victims of violence because of the way our health professionals continue to indulge in compartmentalization . . . the vertical separation of one life-saving service or discipline from all others.

It's a frustrating habit we've developed, but one which we agree should be ended as soon as possible and as effectively as possible.

For just that reason, we have a range of disciplines, skills, and experience represented at this workshop. Through our own multidisciplinary deliberations, we might produce recommendations for the profession of medicine, for example, that not only reflect actual and potential medical practice, but also reflect the contributions of social services, nursing, and law enforcement, as appropriate.

Ideally, the multidisciplinary approach we're taking here in Leesburg ought to be replicated in every community in the Nation. I say "ought to," but I know it can't be accomplished in most of the country. Therefore, reality dictates that we produce here the kinds of recommendations that reflect the thinking of many disciplines, yet recommendations that can be — themselves — the stimuli of change and progress everywhere.

Here, again, through the "Delphi" technique, we seem to have reached general agreement on another idea, and that is the fact that we've had ample time to develop our theories and concepts. What we need now — and what the *country* needs now — is action.

Our recommendations, then, ought to be framed in such clear, direct language that our colleagues in medicine, nursing, psychology, and social

service anywhere in the country can absorb them, understand them, and put them into practice.

- We need to make such recommendations for all the health services . . . how they might be organized, how they should interact, how they ought to respond to the needs of victims of violence, and how they should contribute to the prevention of violence. To say we're in favor of a multidisciplinary approach is obviously not enough. We need to focus in on those current multidisciplinary programs that seem to work . . . to isolate and describe their elements . . . and then indicate how they can be replicated in any community or institution.

- We also need to be just as pragmatic in the area of education and information. How can we get certain life-protective messages across to young people? . . . to our elderly? . . . and to our colleagues in the health professions? And what role could our public schools, our professional schools, and our professional associations play in this educational effort? And what ought to be the role of the media . . . television, radio, newspapers, magazines?

- While we might feel we have learned enough from research and experience to move forward into action, there are still many areas — especially in the field of human behavior — where we could use more specific information based on good research and demonstrations. I hope these will be discussed here and later put forward among your recommendations, also.

From these two days of hard work should come a document that can be read in two ways. One way would be to read the recommendations, one by one, for the evaluation and treatment of victims and for the prevention of violence. These recommendations could apply to the various professions, to local and state governments, to voluntary organizations, and to academia according to a cross-grid of the different kinds of interpersonal violence: child abuse, spouse abuse, rape, and so on.

The second way to read the document would be not as specifics but as an overall strategic design.

One of the great deficits of our health delivery system generally has been its stubborn resistance to the development of any overall strategy of care. I will not concede that there's a good reason for this because there isn't.

But there is a bad reason. And that reason is our own unwillingness to

really try. We have become so used to a health system that grows and changes incrementally that we think that's the way things ought to be.

But that's not so.

And so I would hope that here at Leesburg we would not fall into the same particularistic trap that we bemoan as existing everywhere else.

Let's not do that. Let us instead arrive at a set of recommendations that make sense by themselves . . . but make even *more* sense when they are perceived together, sewn throughout a seamless fabric of lifesaving, dignity-preserving, quality health care.

I want that to happen here at Leesburg. I believe it's an assignment that is worthy of the knowledge, experience, and reputations assembled in this room.

And now a closing word.

It had been our intention to take the recommendations of the Leesburg Workshop back into Washington, D.C., and hold a press conference on Wednesday morning to make our findings public. However, I believe we've been given an opportunity to start the public education effort in a very important way.

Special Senate Hearing

I'm pleased to report to you that at 11:00 a.m. on Wednesday morning, we will be appearing before the Senate Subcommittee on Children, Families, Drugs, and Alcoholism to report on what will have transpired at this workshop. We are going at the invitation of the Chair of that Subcommittee, Senator Paula Hawkins of Florida, who has been a strong voice in the Congress on behalf of human life and family values.

I say "*we*" have been invited because Senator Hawkins has graciously asked six of our 11 work–group chairpersons to appear with me. They are Douglas Sargent, Anne Flitcraft, Lee Ann Hoff, John Waller, Jean Goodwin, and Jordan Kosberg. They will speak not for themselves, obviously, but on behalf of all of us. I deem it a great privilege to travel in such company. In fact, I'm delighted to go to Capitol Hill with any company at all. But especially with these six.

It's getting late and I know many of you are eager to exchange greetings with colleagues, visit the special presentations arranged in the meeting rooms as part of the "information exchange" this evening, and prepare for tomorrow's work.

So I will close with a little quotation from one of my favorite American writers, Henry David Thoreau. He seems appropriate for this setting.

In his marvelous book, *Walden*, Thoreau wrote, "It is characteristic of wisdom not to do desperate things."

So let us turn to our work with patience and wisdom, and not out of desperation. Instead, let us pledge that despair is over . . . for *all* our people.

And let's start here.

Thank you.

Plenary Session II

Interpersonal Violence and Public Health Care: New Directions, New Challenges

Presented by Marvin E. Wolfgang, PhD
Director, Sellin Center for Studies in Criminology and Criminal Law, University of Pennsylvania*
Monday morning, October 28, 1985

The Founding Fathers of our nation had the wisdom and foresight to remind us in the Preamble of the Constitution of the great challenges and goals that lay ahead. Six national purposes, charges, and mandates for the future were boldly inscribed there as part of the national consciousness. As a nation we have sought in common cause to fulfill those purposes. To nurture and preserve that more perfect union after which our forebears sought, the nation has had to remain vigilant to protect its spirit and body from threats from both without and within. One of the most damaging and pernicious internal threats that has taken on major proportions over the course of our history is violence in its many forms and gravities.

Deep and longstanding concern about our nation's violent past and present produced the presidential appointment of the National Commission

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* With Neil Alan Weiner, Research Associate, Sellin Center for Studies in Criminology and Criminal Law, University of Pennsylvania.

on the Causes and Prevention of Violence in 1968. For the first time at the national level this dark side of our heritage was illuminated systematically and in depth. The summary of the 13-volume report prepared by the Violence Commission chronicled with precision this enduring and pervasive national malady (U.S. Violence Commission 1969). Among the community of nations most similar to our own in culture and history, those modern, stable democratic states of Western Europe, our nation was planted at the summit in levels of lethal interpersonal criminal violence and collective civil violence. More recent documentation confirms these observations and suggests that America is also an international leader in nonlethal forms of assaultive conduct (Archer and Gartner 1984; Wolfgang and Weiner 1985). Indeed, as the Violence Commission established, the 1960s witnessed levels of violence which were substantially greater than those of preceding decades and ranked among the most violent in our history.

Since the 1969 report of the Violence Commission, levels of violence in our national community have increased dramatically, if we use official police records of criminal violence; or they have remained fairly stable since 1973 but at much higher levels than those documented by police sources, if we use reports of criminal victimizations (U.S. Department of Justice 1984; Weiner and Wolfgang 1985). Our nation not only suffers losses of stature and moral example because of its levels of violence, which exceed the proportions of kindred nation states, but also finds itself at its zenith in this ignobling respect.

Focus on "Tranquility"

The Violence Commission elected to carry out its charge by focusing on the means "to establish justice and to insure domestic tranquility," the first two national purposes penned in the Preamble to the Constitution. Tensions between justice and public tranquility and order were guiding concerns in the quest of the Violence Commission to understand and to prevent violence. In that analytical and philosophical context, violent disorder was dissected with the cutting instrument of criminal law and the system of criminal justice. Although various theories were used to reveal the causes of violence, the primary inquiry was from the viewpoint of violative and unlawful behavior.

The Founding Fathers seemed prescient in their deliberations and constitutional framing. They inscribed another viewpoint and objective into this nation's first legal document: namely, the promotion of the general welfare. Now this workshop on violence is fueled by that original national purpose. The disorders of violence are as much a challenge to the general

health and welfare of our nation as they are to its system of justice and law. Our objective at this assembly is to wed to the insights and advancements of law, order, and stability, those of public health and welfare.

Fused to "America the Beautiful" has been "America the Violent." Ours is a land in which people inflict morbidities and exact premature mortalities in enormous proportions and in many different ways. The nation has been, and continues to be, fearful of these assaults and related victimizations (Weiner and Wolfgang 1984).

The formal promotion of the public health initiative in response to violence is dated with the presentation of the U.S. Surgeon General's national health agenda, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services 1979), which identified 15 priority areas that, with properly targeted preventive interventions, would improve appreciably the health of the nation. This document was the wellspring from which soon flowed quantified and feasible policies to reduce violence and other threats to the national health and vitality (U.S. Department of Health and Human Services 1980). Our current workshop on violence, a direct outgrowth of these milestone precedents, can inaugurate a major and continuing enterprise by health care professionals to prevent and to heal the many wounds inflicted by violence on our nation's physical, emotional, and cultural corpus.

A Catastrophe and a Challenge

Many sources can be consulted to document the extent and character of these lethal and nonlethal interpersonal exchanges. Some of these sources are more reliable and nationally representative than others. However, one need not search much beyond the pages of the background papers prepared for this workshop to obtain a measured and riveting picture of the catastrophe and challenge which confronts the nation (U.S. Surgeon General 1985). Consider the most grave interpersonal exchanges. Homicide ranked as the 11th leading cause of death of Americans in 1980. Approximately 24,000 Americans died by the hand of another in that year, resulting in 690,000 potential years of life lost. These deadly assaults comprised one-seventh of all deaths by injury (Baker, O'Neill, and Karpf 1984). Most grimly, for a young black male aged 15 to 24, homicide is now *the* most likely cause of death. Indeed, over his lifetime, a black male is burdened by one chance in 21, compared to one chance in 131 for a white male, of dying in a lethal encounter (U.S. Department of Justice 1985). But the proportions of lethal exchanges are dwarfed by the numbers of morbid

nonlethal incidents. More than 1.5 million aggravated assaults of Americans age 12 or older were reported in 1980, representing a substantial number, indeed, of instances in which a deadly drama might have unfolded and been played out to a lethal conclusion.

These lethal and gravely assaultive episodes have their contexts of occurrence which shape the likelihood and character of the injurious interplay. It is fitting that the patterns in interpersonal violence which form the primary focus of this workshop are those imbedded in the family. The national tranquility is deeply afflicted by these disturbances in the domestic microcosm.

That intimate nuclear family unit which broke bread together at dusk and which huddled close to hearth and home forms a rich part of the national lore and folk imagery. But the American family has also had its darker side which has rarely turned public. As we are finding increasingly, the family united in common purpose and objective is frequently more a myth than a reality. Domestic life is often rent from within, making enemies of intimates. Domestic tranquility is, as we are becoming more aware, threatened profoundly by its internal dissentions, disruptions, and injurious and deadly conflicts.

Tallies vary, but convergent data point to between five and 20 percent of the adult population as being enmeshed in some form of spousal abuse, comprising approximately four million domestic partners. Nearly 50 percent of those husbands who batter their wives do so with brutal regularity, three or more times a year. Other data, from the National Crime Survey, indicate that nearly one-third of the nation's abused women are serially victimized. Spousal abuse may, in fact, be the foremost cause of injury to women.

Nor are the nation's children immune from assaults and batterings and sexual attacks by their parents and other guardians and caretakers. A recent national survey projected that nearly 1.5 million children and adolescents are subjected to abusive physical violence each year (Gelles and Cornell 1985).

Many abused children are sexually violated, forcefully or through the implicit threats of a parent or caretaker in a position of authority and power. Scant information exists but some figures are enlightening and alarming. In 1984, nearly 125,000 cases of sexually abused male and female children were reported to authorities. Prevalence figures for women who were sexually abused before age 16 run between 25 and 50 percent. Peak abuse ages for male and female children fall between 9 and 12. Between one-quarter and one-half of the abuse cases involve a family member or relative.

Little reliable information has been marshalled about the extent and outcomes of domestic violence suffered by the elderly. What few studies have been conducted are more exploratory than comprehensive. In view of the patterns and proportions of other forms of familial violence, it is unlikely that we will be heartened when these hidden figures are uncovered.

The domestic crucible is becoming increasingly recognized as having profound effects, both immediate and long-term, on its members who experience violence directly or indirectly. Physical pain and suffering and related physical morbidities are the more obvious distressing outcomes. Disturbances in emotional and social development and in important cognitive skills are, likewise, the insidious legacy of domestic violence. These consequences are now documented with greater regularity, as you are all aware.

Long-Lasting Effects

Of equal concern is the effect that domestic violence, particularly against our nation's children, can have on shaping similar behavioral forms beyond the domestic circle. Perhaps most disquieting, children who are battered, or who witness physical assaults among other family members, are more likely to carry the force of these episodes into their nonfamilial interactions in the form of a heightened chance of employing violence as a presumed legitimate interpersonal strategy. The legacy of the violent family is the enhanced risk of applying variations of this same violent behavior in contexts beyond the family setting.

The proportions and gravity of family violence and its facilitation of collateral forms of interpersonal violence argue persuasively for selecting the family as the locus of a primary initiative to apply health care approaches to the reduction and control of violence. The benefits and conquests of the medical and public health models are well known with respect to controlling and, in some cases, eradicating disease and the behavioral contributions to poor hygiene and health. Descriptive and analytical epidemiological research and practice have met great challenges of disease and injury on many fronts: in identifying high-risk populations, in tracing the mechanisms by which theoretical risk is turned into actual malady, and in applying the tripartite prevention strategy — primary, secondary, and tertiary interventions — based on epidemiological breakthroughs into preventive and control regimens. Agents, environments, and hosts have each been proper foci in meeting the challenge of disease control.

The instruments of the health care provider, the conceptual and meth-

odological perspectives employed in public health care, and the modalities of assistance and intervention that are practiced routinely in the health care setting have a legitimate and firm place as part of our national armament against interpersonal violence. Past medical and health care applications in this area, primarily in application to crime in general and to violent crime more specifically, have been restricted to a subordinate part of criminal justice and social problem perspectives. These applications formed what has been termed the "rehabilitative ideal" in criminology and criminal justice. Medical models of disease and pathology were transplanted from their indigenous public and private health settings and installed within the coercive regimes of our courts, prisons, and correctional facilities. The agents of crime and violence were the target of secondary prevention strategies. As substantial recent reviews of these efforts have shown, this restricted initial wedding of medical philosophies with criminal and penal philosophies has had impoverished results (Martin, Sechrest, and Redner 1981; Sechrest, White, and Brown 1979).

Discontent with the rehabilitative ideal has recently turned many of our colleagues to search for alternative ways to control serious behavioral outcomes such as lethal and nonlethal violence. Proposals of deterrence and incapacitation circulate widely and are undergoing continued close scrutiny. These strategies have unclear feasibilities and uncertain magnitudes of effect (Blumstein, Cohen, and Nagin 1978).

The time is propitious for public health perspectives to enter the arena of disciplinary and theoretical thought about the etiology of violent conduct. There are now no clear and strong positions about how to proceed in containing and, perhaps in some cases, eradicating interpersonal violence. The wisdom of many perspectives — particularly one such as your own which has won many battles against injurious hosts, agents, and environments — should contribute substantially to efforts to curb the advancement of interpersonal violence.

As central to the public health approach as its conceptual and methodological armaments is the position that health care is best learned, performed, and maintained when it is ingrained as part of individual and community hygiene, as part of daily routines and salient perceptions of what constitute good health practices. Preventive and control strategies which do not enlist the routine cooperation of those who are to benefit from these strategies can have some success but not as much as they might. Both the American public and those health care practitioners charged with securing the public safety and welfare must learn to consider violence prevention and control as part of their daily requirements and responsi-

bilities. The American people must feel free to appeal to family life centers, drop-in crisis centers, and in-home service programs, to name but a few of our emerging responses to violence, without fear of social stigma, reprobation, or sanction. Our nation must feel as comfortable controlling its violent behavioral urges and practices as it does in controlling bacterial, viral, and physical mechanisms of morbidity and death.

The responsibility to stand firm against interpersonal violence is not the exclusive preserve and discharge of our contemporary public caretakers and monitors — our law enforcers. Although criminal justice approaches may have their place and effectiveness as part of violence control strategies — such as the recent Minneapolis study of police response patterns to domestic violence suggests (Sherman and Berk 1984) — these strategies do not enlist the sensibilities and commitment of our communities. Public health care has been a leader in taking steps to form alliances and networks to make health concerns permanent public priorities and part of personal practices. Winning the public to the cause of treating violence as a health concern may well be, along with its research and methodological equipment, one of the major contributions of public health services.

Many participants here today, who represent diverse disciplines, travel in partnership to a common understanding of interpersonal violence and, by virtue of that understanding, seek to treat the causes and correlates of that violence. But there are barriers to reaching this common understanding, many of which have been articulated by the contributors to the workshop *Source Book*.

An Expanded Data Base

Epidemiological approaches to describing and analyzing violence require reliably gathered and valid information. Particularly important are longitudinal data that span the lifecourse of subjects and reflect the many settings, domestic and otherwise, which influence the origins and development of violent behavior. These data must include persons who are subjected to violent assaults and those who are responsible for assaults as well as the situations in which assaults occur. In the lexicon of health care, basic, extensive, and quality information is needed about hosts, agents, and environments. With these data, the progression and vicissitudes of violent careers, as we now refer to them in our criminological pursuits, can be examined effectively and precisely.

The collection and maximum utilization of primary data sources is, then, a priority which needs continued and substantial support. Because lifespan data often demand substantial time for collection and analysis, practitioners

who seek to use and apply the fruits of such research data must be patient while they are gathered and analyzed. Moreover, to realize our goal of diminishing the ravages of interpersonal violence, solid evaluation of programs which respond to these physical onslaughts must be initiated. All who are here should recognize this need. Greater efforts to conduct proper assessments of violence reduction and control modalities are integral to rational efforts to establish and perpetuate those modalities which, in a word, work.

Law and Liberty

Our analytical and social service initiatives must be joined to considerations of law and justice. Complex issues of personal and collective freedom and protection collide in the arena of violence legislation about dangerousness. Protective service action exemplifies this legal tension. What are the proper limits of intervention? At what point may health care practitioners legally and coercively enter domestic settings? When might such entry constitute an unlawful intrusion, a violation of freedom and liberty that may be more deleterious than those practices which the empowerment legislation was intended to curtail?

No less controversial and complex are legal issues about how to control responsibly the explosive armaments which take so many lives each year. We must acknowledge that firearms are used to kill people in the United States in frighteningly great numbers. Socio-cultural differences aside, the ready accessibility of firearms in the United States and their near inaccessibility in Japan probably play a major role in the 10,715 criminal homicides by firearms in the United States in 1980 in contrast to only 48 in Japan. Without this mechanism of death so generally and easily accessible, people would not kill, and people would not die, as frequently as they do.

The resolution of these and other legal questions is a pressing concern which many here in attendance have already begun to address. More attention to these issues will be required as public health care focuses on physical violence and dangerousness.

To meet the needs of data preparation and analysis, of program evaluation, and of framing informed and effective legislation, greater public health efforts to confront violence must be focused and collective.

Surgeon General Koop's challenge to cleanse and to treat the national wounds of our present violence — a challenge he has laid squarely before each of us — can be met only if there is a broad-based, comprehensive agenda and an alliance of participants. Initiatives must be clearly articulated, feasible, and nationally coordinated for the optimum benefit to ensue.

The Surgeon General's office has been and will continue to be a seat of leadership in that enterprise.

But violence cannot be countered by government alone. The strengths of community and common cause are also required to promote health and well-being in our land. An alliance between public and private sectors should promote progress toward reducing violence. Some major private sector initiatives, such as the Eisenhower Foundation, presently exist and provide comprehensive plans for future action (Curtis 1985).

In summary, our common challenge is one of forging a national agenda and alliance in response to interpersonal violence and, by so doing, to promote and safeguard the general welfare. At the vanguard of this enterprise is the authority and good offices of our entrusted advocate of the public health, the Surgeon General. Perhaps this workshop marks the commencement of a dialogue which will culminate in a message from our nation's chief public health officer about the clear and present danger posed to the American people by violent conduct.

Toward achieving, in concert, the goal of forcing a decrease in our nation's violence, we must act with vigor, imagination, and resolve.

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Violence and Public Health

Presented by William H. Foege, MD
Assistant Surgeon General, USPHS, and Special Assistant for
Policy Development, Centers for Disease Control
Monday morning, October 28, 1985

I can't pretend to tell you much about the problem of violence. You come already schooled in the subject, convinced of its importance, and concerned by its impact. I will instead make a few observations about how this compares with other public health problems and what we can learn from our public health experience regarding how to pursue the problem of violence.

An Historical Preview

Throughout history, the two leading causes of early or premature death have been infectious diseases and violence. Infectious disease control started 190 years ago with the work of Jenner, when he developed the first vaccine, smallpox vaccine. Infectious disease control continued along with many nonspecific social changes, such as better nutrition, better housing, and education. In the past 50 years, we have returned to some specific tools, including vaccines, antibiotics, and pesticides.

On the other hand, violence has defied the best minds in health, politics, religion, and law enforcement, and therefore has often appeared to be inevitable. This and other forms of fatalism must be actively opposed. That we live in a cause-and-effect world is as true with violence as with infectious diseases, an important observation for both public health people and educators.

Another important observation is that public health is in the business of continually redefining the unacceptable. This changes the social norm which in turn changes the problem. For example, 35 years ago, polio was the inevitable price of summer in this country. With the widespread use of polio vaccine 30 years ago, the social norm in this country quickly changed. However, for the hemisphere as a whole, the social norm has been polio control or relatively low levels of polio disease. On May 14 of this year, the Regional Director of the Pan American Health Organization announced that polio would be eliminated from this hemisphere by 1990.

With that one announcement, the social norm changed, and it instantly became unacceptable to have any cases of polio in this hemisphere.

This conference is an important step in redefining the unacceptable in interpersonal violence. It is a major step in enlisting the public health structure of this country in changing the social norm. It should be understood that many have seen violence as being unacceptable just as many saw polio as being unacceptable. But until recently, violence has not been regarded as a public health problem. Rather, it has been viewed as a law enforcement problem, or as a transportation problem, or a welfare problem. Dr. Koop is largely responsible for putting this on the public health agenda.

Recent Developments

In 1977, a group began looking at morbidity and mortality in this country to advise on the 12 most important things that could be done in prevention. They made popular the notion of not only looking at the leading causes of death but also looking at the leading causes of years lost before age 65. While heart disease, cancer, and stroke lead the list of causes of death, the leading causes of years lost prematurely are accidents, cancer, heart disease, homicide, and suicide. Therefore, three of the five leading causes of premature death are related to violence. It was because of this finding that we started a program of violence epidemiology at CDC and hired Dr. Mark Rosenberg who has training in both psychiatry and epidemiology to head that program.

In 1979, the Surgeon General published his book *Healthy People*, outlining the 15 priority areas requiring national attention in prevention. Also in 1979, the first meetings of health people from around the country were held to develop the 1990 objectives, a set of over 220 specific objectives of where the United States should be in health by 1990. These include specific objectives on homicide rates, child abuse rates, and suicide, as well as on specific risk factors. This national prevention strategy is a landmark in public health, and it is important that violence is a part of the strategy.

In 1985, the National Academy of Sciences and the Institute of Medicine published *Injury in America — A Continuing Public Health Problem*. It pointed out that injury, both intentional and unintentional, remains the major unaddressed public health problem of our day. While injury accounts for 4.1 million years of life lost before age 65 each year, heart disease and cancer combined account for only 3.8 million years lost before age 65. Yet, we spend $1.622 billion per year on research for the latter and only seven percent of that amount on injury research.

Basic to every successful public health effort has been the development of an appropriate surveillance system. This was true of the public health pioneers, such as Jenner, Snow, and Semmelweiss, who did limited but rigorous surveillance of a microcosm; but it is also true of the institutional pioneers who have developed surveillance of cities, provinces, and then entire countries.

The first nationwide surveillance system for any disease in this country was not instituted until 1950. That system was developed for malaria and made the startling discovery that indigenous malaria had quietly disappeared from this country some time in the 1940s without being noticed. We did not organize another nationwide surveillance program for five more years. In 1955, because of a problem with polio vaccine which still contained virulent virus, a nationwide poliomyelitis surveillance program was launched, literally overnight.

Global surveillance for a disease was not developed until the late 1960s as part of the smallpox eradication program. While it may appear late to develop violence surveillance programs, in fact, surveillance in general is in its infancy.

Surveillance is essential if there is to be a concerted effort in violence control. We must define all aspects of the problem, collect relevant and correct data, analyze that data in order to define interventions, and measure the impact of those interventions. There are no short cuts. While we are beginning to get better mortality data by age, sex, time, and geography for homicide, we are only beginning to understand the dimensions of nonfatal outcomes. As Mark Rosenberg has pointed out, that may represent an even larger social problem than mortality. And we are a long way from knowing how best to use that information to suggest the generic changes most likely to have a favorable impact.

The Context of Violence

While good national surveillance is one key lesson, another is the need to understand violence in its broad context. Most certainly, we should view intentional and unintentional violence together. The surveillance network needs are similar; the risk groups overlap; the risk factors, such as alcohol and depression, overlap; and the instruments, such as cars and guns, overlap. But in addition, violence is not limited to physical injury. Deprivations of many kinds are forms of violence. Discrimination is a form of social violence, as is poverty. Indeed, Gandhi once said that poverty is the worst form of violence. And the threat of nuclear war constitutes a violent cloud over all of us.

While study requires us to narrow the focus, just as we do when studying the nervous system or the gastrointestinal system, this study must be done within a conceptual framework that understands the broad scope of violence. It is important to capture the momentum of nonviolent movements and prevent fragmentation of our efforts. The recognition of the International Physicians for the Prevention of Nuclear War for this year's Nobel Peace Prize is a significant indication of anti-violence movements which should be incorporated in the total effort.

Role of Health Departments

Health departments should be seen as crucial and essential but not sufficient. This is a lesson learned in many areas, even in what is regarded as standard public health. Health departments are simply not strong enough, sufficiently influential, nor rich enough to carry out programs by themselves. Around the world, we see this with immunization programs which become possible only when political leaders and others provide their support. In the United States, polio immunization rates were as low as 65 percent in 1977. It was not until the executive and legislative branches of government became involved with the states and counties, as well as education departments, PTAs, volunteer groups, etc., that immunization rates in this country went to 80 percent, 90 percent, and finally to 97 percent. This comes close to a program of perfection, but it could not have been done by health departments alone.

With violence, it is even more important to have the largest diversity of professional and volunteer groups possible if a significant impact is to be realized.

What then should be the role of health departments? *First*, health departments could assist to get violence into the mainstream of public health. Public health could provide the constituency that anti-violence now lacks. *Second*, health departments could be involved in problem definition, an area of considerable experience and expertise. *Third*, health departments could be involved in the education of politicians and those who could change what is now done, education of children through the development of appropriate curricula, and education of the public by providing information to the media. *Fourth*, health departments should develop intervention strategies and evaluate their impact. *Fifth*, health departments must work to keep this interest from being a fad. They must develop the stabilizing interest to sustain a search for answers into the future. This is particularly true if early intervention efforts turn out to be misplaced.

It is important for the Federal Government to provide leadership, as is being done with this conference. But it is essential that you not wait for the Federal Government to develop a program. Most health programs at the federal level have evolved because of convincing demonstrations at local levels. This was true for the immunization program which was built on many private, local, and state demonstrations. One of the telling examples is the use of child restraints in this country. The Federal Government for a variety of reasons could not or did not provide leadership. A pediatrician and local health officer in Tennessee worked at county and then the state level to get the first child restraint law passed in Tennessee. In only a few years, all states had followed the example.

It is important to promote a groundswell of trials, demonstrations, and suggestions from private sources as well as local and state health departments. Many pilot projects of varied types increase the chance of funding some interventions that are worth replicating. You force the federal establishment best by demonstrating something so compelling that it has to be replicated (as with child restraints).

International Implications

Finally, remember the international aspects of violence. We saw the disparity in homicide rates by country and the exceptionally high burden of violence endured by many. Although the developing world is quite correctly concerned with reducing its infectious disease rate, some Third World countries are already losing more premature years to violence than to infectious diseases. A broad perspective in studying violence and developing intervention strategies will serve the world most completely.

Smallpox is the only disease to have been eliminated from the world. As a person interested in that program, as well as international health generally, I can assure you that you are on the ground floor of something more fundamental and ultimately more important than smallpox eradication. The single most important lesson of smallpox eradication was the demonstration that it is possible to plan a rational health future. What you are now doing is a step — a vital step — in planning a rational future for combatting violence.

Plenary Session III

Interpersonal Violence: A Comprehensive Model in a Hospital Setting — From Policy to Program

Presented by Karil S. Klingbeil, MSW, ACSW
Assistant Professor, School of Social Work, and Assistant Administrator, Director of Social Work, Harborview Medical Center, University of Washington, Seattle
Monday morning, October 28, 1985

Over the past several years, there has been an increasing focus on family violence: the issues, the characteristics, the components, the etiology, and intervention/prevention strategies. This focus on violence comes at a time when we have evidenced dramatic changes in the health of our citizenry. Many successful advances in treating illness and communicable disease are well known. The attention to traumatic injuries, then, and the development of major emergency facilities and trauma centers across the nation have literally forced health care providers to deal with all types of catastrophic injuries. Included are trauma injuries from interpersonal violence, both intra-family violence and extra-family violence. Gunshot wounds, knifings, physical beatings from other "lethal" weapons, sexual assaults, elder abuse, and the psychological aftermath plague the provider. The picture that has

emerged is a frightening one. Clearly, family violence is a major public health concern and requires a community response.

As with most health care issues, clinical demands and frustrations precede the scientific explorations, and family violence has followed this pattern. Particularly evident over the years has been the frustration of emergency room personnel as physical injuries from family violence have dramatically escalated, and police, medics, and others have brought victims by the thousands for emerging care. Many have literally been saved from "death's door," while others have not been so lucky. Even those "saved" often return to the precarious environment from whence they came, only to repeat their journeys to the emergency facilities, much to the disgust and ongoing frustration of the health care, criminal justice, and social service systems. Further, while emergency medicine has become a certified medical specialty, emergency room personnel are still ill-prepared to deal with the emotional and psychological impact of family violence. Emergency rooms also function as social service agencies after 5:00 pm and on weekends, when most agencies are closed and victims of violence gravitate to emergency rooms for psychological as well as physical attention. Whether emergency room staff are prepared or not, they must deal on a round-the-clock basis with all aspects of interpersonal violence.

Priority Populations

Harborview Medical Center, founded in 1877, is a 340-bed tertiary care teaching hospital affiliated with the University of Washington in Seattle. From its inception, Harborview has served the indigent medically ill of King County. Its priority populations, announced by the Board of Trustees in 1984, are persons in the King County jail; mentally ill patients, particularly those treated involuntarily; persons with sexually transmitted diseases; substance abusers; indigent patients without third-party coverage; non-English-speaking poor; trauma patients; burn patients; and those requiring specialized emergency care (victims/perpetrators of violence).

Harborview Medical Center is also the major emergency facility in Seattle, King County, and the Pacific Northwest. Most medical, psychiatric, and psychosocial emergencies are brought to Harborview's Emergency Trauma Center (ETC). Specific county commitments with the Division of Human Services, including the Involuntary Treatment System (ITS) and the Division of Alcohol Services (DAS), bring the acutely disturbed psychiatric patient and the excessively intoxicated patient for care. In addition, because Harborview is a designated regional trauma center for the Pacific Northwest,

it provides care to the majority of multiply injured patients in Seattle and surrounding environs, including the states of Washington, Alaska, Montana, and Idaho (referred to as the WAMI region). Annual traffic through the ETC averages 40,000 visits in a city and county with a combined population of 1.3 million.

It was from this clinical experience, coupled with an interest and commitment to help as well as to prevent, that the Harborview Medical Center project on interpersonal violence developed. The results of violence are most frequently treated in hospital emergency rooms. Thus, the emergency room has a unique opportunity to identify, intervene, assess, and treat interpersonal violence. The emergency room provides access to a population that often is too frightened or ashamed to seek assistance from traditional social work agencies; these patients seek the anonymity of a large, busy, often impersonal health facility (Clement, J., unpublished paper, 1985).

The Social Work program in the emergency room began in 1971. One of the goals was to evaluate needs of the emergency room population and to develop programs sensitive and responsive to those needs. In the next decade a series of problem areas were identified and clinical protocols for intervention initiated. The Social Work Director and the Medical Director of the emergency room wanted very much to provide services to victims of violence and provide leadership in the area of interpersonal violence throughout the city, county, and state. The goal was to define the health problems of a patient not just by the presenting symptom but by the primary diagnosis. This meant that a women's broken arm may need to be explored as a case of domestic assault, that a seizure or pancreatitis may indicate a need to explore the patient's alcohol use, or that a straight wrist laceration might require exploration as a suicide attempt.

Six Different Protocols

The clinical protocols established a standardized model of detection, assessment, and intervention specifically for victims of interpersonal violence. They now include the Child Abuse Protocol, the Adult Abuse Protocol (wife battering, spouse battering, partner battering), the Sexual Assault Protocols (including incest victims, male and female), and the Elder Abuse Protocol. The Grief Reaction Protocol addresses services to family members of suicide and homicide victims. The Psychiatric Evaluation Protocol provides services to patients with a psychiatric illness or alcoholism who have been violent or who have the potential for violence and are "at risk." The beginning of the intervention process is dictated by "criteria for involve-

ment" by the social worker. It remains imperative that the criteria be as broad as possible, rather than include only those persons who are clearly identified as victims (Clement, J., unpublished paper, 1985). This initial approach is the key to detection of all problems of family violence and sets the scene for early intervention and prevention.

(For additional information on the Social Work program in the emergency room, the reader is referred to "Social Work in the Emergency Room," Clement, J. and Klingbeil, K. in *Health and Social Work*, November, 1981 and "Emergency Room Intervention: Detection, Assessment, and Treatment" by Klingbeil, K. and Boyd, V. in *Battered Women and Their Families*, Springer Publications, 1984.)

This paper presents a comprehensive model for handling interpersonal violence in a hospital emergency room. The goal is to recognize, detect, assess, and treat all forms of violence against persons. This model, while initially established in a hospital-based emergency room, is applicable and replicable in other settings as well. Special focus is on tertiary and secondary prevention; however, the model does address primary prevention of interpersonal violence as an overall but often elusive goal. Complementary to the model is the necessity to consider allocations of personnel, including support staff, other budgetary considerations, and space allocation.

These are the steps for development of the comprehensive model.

1. Policy Statement

The first step is the clear articulation of a policy statement sanctioned by the governing board or executive body of the institution. This is critical for any program in interpersonal and family violence. Myths and personal judgments continue to cloud the detection of violence between relatives, friends, acquaintances, or strangers. A policy statement demonstrates commitment, sets priorities of staff time and resources, and requires the administration, through the budgetary process, to allocate monies to an interpersonal violence program.

Institutional commitment to a policy of non-violence is a major step toward primary prevention and is as important to staff as to clientele.

This is an example of a policy statement:

"Harborview Medical Center (Faculty, Staff, Departments) acknowledges a responsibility in the tertiary, secondary, and primary prevention of violence. This includes the detection, assessment, and diagnosis of all aspects of interpersonal violence, the identification of high risk individuals and

groups, and the development of resource networks and/or primary preventive efforts as resources permit.

"The policy addresses two major areas:

A. Intra-Family Violence

1. Spouse battering
2. Wife battering
3. Marital rape
4. Child abuse
5. Incest (child sexual abuse)
6. Sibling abuse
7. Elder abuse
8. Abuse of parents by children

B. Extra-Family Violence

All forms of violent acts against another person not related in an intimate situation.

"Suicide attempts (and homicides) are frequently present in the above categories and require the use of the Psychiatric Protocol for assessment purposes. The interventions may differ, but sensitive and nonjudgmental assessment and diagnosis is imperative. It is important to note that the major difference between A. (Intra-Family) and B. (Extra-Family) is in the definition of the relationship: *i.e.*, violence occurring in the context or absence of intimacy."

The appointment of a hospital-wide committee on interpersonal violence is detailed in Step 3 (see below), but could be included as part of a policy statement.

2. Background/Justification Data

After the policy statement comes the justification of the program, with appropriate background and substantiating information. This includes information on specific problems, such as child abuse, wife battering, suicide attempts, etc. This second step also requires a definition of terminology, including the kinds of abuse and the distinction between abuse and battering. Abuse occurs in the physical, psychological, sexual, and environmental contexts. Additionally, there should be a statement of philosophy, principles, and the identification of high risk individuals or groups by critical identifiers for diagnostic purposes.

Thus, step two addresses the following key areas:

A. problem statement
B. definition of terms
C. philosophy
D. principles: standards of practice

E. magnitude of the problems — statistics
F. demographics, if applicable
G. behavioral characteristics or descriptions
H. identification of high risk individuals/groups
I. bibliography and references

This second step clearly articulates the justification and philosophy for a violence program in the emergency room. In other words, anyone reading Step 2 would understand the extent of the problem, the need for intervention, methods of intervention, etc.

Philosophy is important to any program, particularly one where there are varying opinions and myths that prohibit appropriate diagnosis and intervention. A comprehensive philosophy should include a statement on non-violence as a way of life — that violence is not justified in any relationship except in self-defense. Additionally, it should address the continuum of violence, from child abuse to elder abuse. It should clearly address prevention and lay the groundwork for education of client and professional.

Definitions can be relatively simple: for example, ". . . family violence is defined as behavior toward a family member that would evoke legal action if directed toward a stranger." ("Family Violence Principles of Intervention and Prevention," Jean Goodwin, M.D., *Hospital and Community Psychiatry*, Oct. 1985). Or family violence includes any act of force or coercion against another person without his or her permission.

Additional philosophical statements can deal with treatment strategies, advocacy, community resource building, and networking.

3. Procedures

The third step in this model is the development of specific, recommended approaches to various problem areas in interpersonal violence. Obviously the emergency room would have quite specific and detailed protocols pertaining to interpersonal violence, while other departments in the hospital might not. All departments, however, should have written procedures in concert with the overall hospital policy. As an example, a nursing department policy/procedural statement might address staff development and inservice training in support of the overall hospital violence policy.

The third step would include protocols, if the department is involved in "hands on" tertiary care. Otherwise, a statement of how department policies mesh with hospital policy will suffice.

A sub-step is the development of literature, including brochures and pamphlets on community resources as handouts to patients and their fam-

ilies. Copies of regulations and/or the law should also be available, either attached to a specific protocol or referred to in a department procedure. Both brochures and copies of appropriate laws might be included in the patient's admission packet, but would in any case be available in the emergency room as handouts.

An overall multidisciplinary hospital committee on interpersonal violence should be established. This committee could assure continued attention to protocols, referrals, resources, and resource allocation (including staff time, and budget). The committee should review hospital policy and update it as needed. Additionally, the committee could focus on political issues in the community, including public policy issues, statewide as well as local funding issues, and environmental trends. Secondary and primary prevention involve activities well beyond direct service, such as advocacy and testimony regarding proposed legislation. A hospital committee can provide leadership through legislative action. An interdisciplinary or multidisciplinary hospital committee can advance staff training on various levels, such as employee orientations to "Violence Rounds," a major educational pathway.

4. Protocols

The fourth step includes the development of specific clinical protocols for use in the emergency room. The clinical protocols include:

A) Adult Abuse Protocol
B) Child Abuse Protocol
C) Sexual Assault Protocol
D) Incest Protocol
E) Elder Abuse Protocol
F) Psychiatric Evaluation Protocol
G) Alcohol Protocol
H) Grief Reaction Protocol

Protocols should convey a clear commitment to exemplary, non-judgmental patient care. (See Klingbeil, K. and Boyd, V., *Battered Women and Their Families*, Springer Publishers, 1984). This is especially important for standardizing a level of care regardless of previous staff training.

The protocols should include all laws that apply to crimes of violence, reporting requirements, and victim compensation, if applicable.

5. Resource Management

Step 5 calls for the establishment of a resource "bank" or network of community agencies to which victims, families, and perpetrators may be referred. This can involve the development of new programs within the hospital and/or community as needs arise and are identified. This important

step extends the boundaries of the hospital into the community and develops an effective "safety net" for patient care. Conversely, the community comes into the hospital.

Resources can be identified in a number of ways but should include the following:

— Criminal justice system for reporting and investigative purposes, as well as treatment planning.
— Social service system for victims, perpetrators, and children; includes mental health, alcohol, resources, and self-help. Crisis to long-term care facilities should be identified.
— Advocacy and legislative groups, including national professional organizations, such as AMA, APA, APsyA, NASW, ANA, and statewide organizations.
— Religious community
— Welfare agencies
— Health care system
— Educational community

6. Organizational Component

The sixth step concerns the organization of an interpersonal violence program. Specific areas are as follows:

A. Population served
B. Practice and Standards by Discipline
C. Supervision — Peer Review Leadership
D. Knowledge and Skills
E. Protocols — Clinical Aspects
F. Program Development
G. Administrative Structure and Staffing
H. Demographics and Community Trends for the Future
I. Budget

Extra-Family Violence

So far the focus has been on intra-family violence issues. Now let's turn to extra-family violence. To the six steps delineated above we would add the identification of high risk populations in regard to extra-family violence.

The identification of high risk individuals or groups seen in the emergency room is important in secondary prevention. Clinical impressions tell us that many individuals, particularly those involved in extra-family vio-

lence episodes, have previously been seen at hospital and health care settings. To identify these individuals and to intervene prior to a violent act is the purpose of secondary prevention.

These are some of the high risk categories:

1. Psychiatric diagnosis such as depression
2. Alcohol diagnosis (including DWI) and substance abuse
3. Behaviors associated with loss, grief, death
4. Isolation
5. Lack of support system
6. Homelessness
7. Previous history of assault/suicidal behavior
8. Chronic unemployment
9. Presence or use of weapons, previous arrest for crime, etc.
10. Runaway
11. Single auto accidents
12. Psychosomatic complaints

This is a list of "red-flag" antisocial and delinquent behaviors. These categories are important to early case finding and early intervention, since these patients most frequently show up in the emergency room. Their identification would be followed by the use of screening devices, such as violence scales and/or inventories which are particularly useful to an emergency room staff. Many scales and inventories in the trauma literature can be adapted for interpersonal violence behaviors. Emergency room staff could apply such scales to individual patients and hopefully begin to predict the level of lethality in future violent episodes.

Summary

This paper illustrates the steps in a comprehensive model for the identification, assessment, and treatment of victims of violence in a hospital setting. A crucial step is the use of clinical protocols which specifically detail the detection, assessment, intervention, and referral procedures.

Various hospitals in the country have moved ahead to develop family violence programs in their emergency rooms and outpatient clinics. Few programs in hospitals have also included extra-family violence.

Once the extra-family violence groups can be identified through protocols such as the psychiatric assessment or alcohol protocol, both assessment and early intervention techniques can be addressed. Assessment and primary diagnosis are imperative to early intervention. Strategies must be developed to identify patients-at-risk and to promote listening, caring, and helping

for this highly vulnerable population. Education of staff is essential. Programs need to be developed that reach out to these people, who frequently do not seek help in the early stages of trouble. Networking with social agencies must be accomplished. Attention should be given to tracking systems, since this population frequently "shops" for care (but confidentiality issues must also be addressed).

It is clear, however, that much can be done to reduce violence in our society without massive new resources. We must begin with the idea that an approach found successful in intra-family violence can be adapted for extra-family violence, too. Protocols can be developed, modified, and expanded. Protocols also lend themselves to audit and quality assurance accountability.

Every hospital in this country should have a policy and procedural manual on interpersonal violence. Lack of attention to this critical area can mean more health care dollars poorly spent and many lives needlessly lost.

Interdisciplinary Interventions Applicable to Prevention of Interpersonal Violence and Homicide in Black Youth

Presented by Deborah Prothrow-Stith, MD
Assistant Professor of Medicine, Boston University School of Medicine, and Attending Physician, Boston Youth Program
Monday morning, October 28, 1985

Interpersonal violence and its most devastating outcome, homicide, are endemic in urban black areas with low socio-economic indicators. Those who are most affected are young and male. Homicide is the leading cause of death for black men ages 15-24 years at a rate of 72.5 for every 100,000[1] and for black men ages 25-44 years at a rate of 125 for every 100,000.[2] These rates are 7-12 times higher than homocide rates for the general population.[3]

Non-fatal interpersonal violence occurs at rates that are at least a magnitude higher than homicide and likely represents an even greater overall cost to society. There is less adequate data on non-fatal interpersonal violence. Emergency room and school data are the best sources of rates for non-fatal interpersonal violence. However, these rates are underestimations because, as we know, many episodes of interpersonal violence are neither treated in emergency rooms nor do they occur in schools.

The Northeastern Ohio Trauma Study measured the incidence of cause-specific trauma by collecting emergency room data for the year 1977. The study reported an assault rate of 862 per 100,000 population. The over-representation of urban blacks of lower socio-economic status was demonstrated in this study as well. The incidence rate for assault in the urban black neighborhood was over twice the total incidence rate and up to six times the lowest neighborhood rate.[4]

School-based data are equally compelling. During the 1969-70 school year, Seattle Public Schools had four assaultive injuries per 1,000 students.[5] In the U.S. generally there are approximately 75,000 assaultive injuries to teachers a year at a rate of 35 per 1,000.[6] A November 1983 publication from the Boston Commission for Safe Schools[7] reported a survey of four public high schools revealing that 50 percent of the teachers and 38 percent of the students reported being victims of a school-based crime during the year. The overrepresentation of urban black students was evident in this

report as well. Black students were suspended at the rate of 17 per 100, compared to a rate of 8 per 100 for white students. A large number of the suspensions (30 percent) are for interpersonal violence.

Weapon-carrying behavior was also reported in this Boston survey. Seventeen percent of the girls and 37 percent of the boys reported bringing a weapon to school at some point during the school year.

Socio-economic factors are thought to account for this overrepresentation of blacks among homicide victims. In a recent Atlanta study data that was corrected for socio-economic status, using the number of people per square foot of housing, no longer showed a racial bias.[8] Urban black adolescents are overrepresented among the poor with unemployment rates of 40-60 percent[9] and are overrepresented among the victims of fatal and non-fatal violence.

The severity and urgency of the problem for urban black communities dictates the need for appropriate and effective prevention strategies. The possibilities for such prevention strategies were greatly enhanced by the recent conceptualization of interpersonal violence as a public health problem.

Traditionally violence was viewed as only a law enforcement problem which limited both the professional expertise and the variety of institutions involved. The traditional public health model attributes occurrence of disease to complicated interactions between the environment, the pathogen (the agent that is responsible for the disease), and the host (the individual with the disease). The traditional public health model has been applied to unintentional injuries. The application of the model to violence prevention offers a particular challenge because of the intentional nature of violence-related injuries.

The public health interventions applied to other problems that have been most successful are those that have manipulated the environment and have had little dependence on changes in human behavior. Yet, when applied to intentional injury, environmental manipulations can be expected to be less effective. For example, a safety lock on the trigger of a handgun could be expected to prevent handgun-related accidents; but this intervention could not be expected to have that same effect on intentional shootings.

Altering the host (victim) and the pathogen (assailant) in this case to prevent interpersonal violence and homicide is dependent on changing human behavior, which is more difficult than altering the environment. The goal in such manipulations is to make the host more resistant to the disease, and the pathogen less virulent. Preventing interpersonal violence in urban young black men requires an appreciation of the distinct similarities between the victim and the assailant, as demonstrated by Ruth

Dennis, Ph.D.[10] Her work compares three groups of black men ages 18-34 who were 1) incarcerated homicide perpetrators; 2) victims of serious assault (knife and gun wounds); and 3) randomly selected non-institutionalized black men found through household sampling. Social and psychological profiles of each participant were done and the three groups were then compared.

The victim and perpetrator groups were similar to each other; they were distinguishable from the control group in that they had less education, had experienced more juvenile detentions, were more likely to carry a gun, and were more likely to have been in jail before. In addition to having similar characteristics distinct from the control group, these two groups had more participants exchange roles (victim vs. perpetrator) during the study. Because of this role exchange and the similarities between victim and perpetrator, when the public health model is applied to interpersonal violence the host and the pathogen become equal, and prevention strategies designed to make the individual less likely to be involved in violence are applicable to both.

These strategies designed to raise an individual's threshold for violence are predominantly education and behavior modification techniques. Teaching conflict resolution and using role play to practice alternatives to violence are such strategies.

The tenuous application of the host, pathogen, and environment disease model is not the most significant gain from the conceptualization of interpersonal violence as a public health problem. Perhaps the most significant gain is the potential application of a multi-institutional and interdisciplinary model which has been applied to other public health initiatives. The national campaign to reduce smoking is an example of such an initiative. The media, health care institutions, public schools, job sites, health fairs, and county fairs become the source of education, information, and incentives. Product labeling and advertisement restrictions are a part of the effort. This approach is applicable to interpersonal violence prevention as well when it is understood as a public health problem. Health education programs like the one I teach are only a piece of the total picture.

The Black Adolescent

Designing violence prevention strategies that are effective with urban black adolescents of lower socio-economic status requires an understanding of adolescence, of issues of race, and of poverty. I will not review all the theories of adolescent development under the impact of race or poverty as

such, though I will offer a general outline of these issues as applicable to the development of violent behavior.

Adolescence is that period of dynamic physical and psychosocial maturation which is the transition from childhood to adulthood. The physical changes are the growth and development of puberty. The psychosocial changes include both cognitive maturation from concrete to abstract thinking and the mastering of specific developmental tasks. These are the major developmental tasks:

1) Individuation from family with the development of same-sex and opposite-sex relationships outside the family.
2) Adjustment to the physical changes of puberty with the development of a healthy sexual identity.
3) Development of a moral character and a personal value system.
4) Preparation for future work and responsibility.

Failure to accomplish these tasks can result in significant dysfunction for the adolescent, which can impair him as an adult. The tasks are accomplished simultaneously and are the major requisites for healthy adulthood. The experience of poverty and of racism can significantly hinder the accomplishment of these essential tasks. The development of a healthy self-identity requires a sense of self-esteem and a healthy racial identity, both of which can be undermined by poverty and racism. Preparing for future work and responsibility is a meaningness enterprise, when unemployment rates are astonishingly high. Developing a sense of moral character and a functional personal value system is also not easy, when television and the street are the main sources of values.

What Is "Normal?"

One of the most difficult problems facing service providers for adolescents is that of defining normal behavior. Normal behavior for adolescents includes a variety of experimental behaviors which at other developmental stages would be abnormal. Defining normal is even more difficult in cases where there is a subcultural experience. Claude Brown in his literary work *Manchild in the Promised Land* describes such an experience:

> "Throughout my childhood in Harlem, nothing was more strongly impressed upon me than the fact that you had to fight and that you should fight. Everybody would accept it if a person was scared to fight, but not if he was so scared that he didn't fight."

The example clearly illustrates the dilemma. How much fighting is too much? When is it problematic? Many would agree that violence in self-

defense is appropriate; yet, if a homicide results, would running not have been a better response? On the other hand, in a violent world, is it not healthier to defend oneself rather than be beaten or harassed?

Narcissism and Sexual Identity

There are several characteristics of adolescence which make a teenager more prone to violence. One such characteristic is narcissism. Narcissism helps the adolescent make the transition from family to the outside world. Yet, this narcissism is also responsible for the extreme self-conscious feelings of adolescents which make them extremely vulnerable to embarrassment. The adolescent feels that he is always in the limelight and on center stage. He is particularly sensitive to verbal attack, and it is nearly impossible for him to minimize or ignore embarrassing phenomena. Another adolescent characteristic that predisposes to violence is the transient stage of extreme sexual identity, or "macho." Establishing a healthy sexual identity requires transient stages of extreme femininity for girls and macho for boys. Macho is often synonymous with violent. The image of a coward is a deadly one for a male adolescent in this stage.

Peer pressure has been labeled the single most important determinant of adolescent behavior.[11] This vulnerability to peer pressure, a normal part of adolescence, facilitates the accomplishment of several of the developmental tasks; yet, it is a characteristic of adolescence which enhances the predisposition for violence. If fighting is the expectation of peers, as illustrated in Claude Brown's quote, then an adolescent is often unable to disregard those expectations.

Erikson[12] describes a societal moratorium from responsibility that is necessary during adolescence to allow the requisite experimental behavior to occur without compromise of future options. Thus, the adolescent is able to experiment with a variety of roles without making a commitment. There is debate as to whether this moratorium occurs at all, yet many agree that in the situation of poverty, it does not. The poor adolescent struggles with developmental tasks without the protection of a societal moratorium.

The black adolescent has to develop healthy racial identity, in addition to the listed developmental tasks. Contact with racism results in anger that appears to contribute to the overrepresentation of black youth in interpersonal violence. Psychologist Ramsey Lewis used "free floating anger" to describe anger not generated by a specific individual or event but from global factors such as racism and limited employment options.[13] This anger is the excess baggage that an individual brings to an encounter that lowers

his threshold for directed anger and violence. This concept is helpful in that it attempts to account for the environmental and socio-economic factors and not label the individual as deficient. The anger is normal and appropriate. Violence prevention is therefore designed to achieve a healthier response to anger, not to eliminate the anger itself.

Violence prevention programs which are appropriate for adolescents developmentally and which have a realistic cultural context can be expected to be effective. Developmentally appropriate programs utilize peers in education and counseling and reflect an understanding of the stages of adolescent development. The cultural context has to acknowledge the violence, racism, and classism that many such adolescents experience.

The problem of interpersonal violence among poor black adolescents has been long appreciated by frontline service providers, and despite an incomplete understanding of the causal factors, prevention and intervention programs have been developed with moderate success. The majority of these prevention programs are either based in a school or linked to a school because of the captive audience. Most are interdisciplinary and multi-institutional.

The Boston Curriculum

The Boston Youth Program is a comprehensive health care initiative for adolescents funded by the Robert Wood Foundation[11]. The health care services are hospital- or clinic-based and the health education/prevention services are school-based. A violence prevention curriculum developed for tenth-grade health students is one of the health education services. The Boston Youth Program curriculum on anger and violence has been instituted in four Boston high schools and one community agency setting. To date, approximately 500 students have received the curriculum. The curriculum is designed to

1) provide statistical information on adolescent violence and homicide;
2) present anger as a normal, potentially constructive emotion;
3) create an awareness in the students for alternatives to fighting by discussing the potential gains and losses from fighting;
4) have students analyze situations preceding a fight and practice avoiding fights by using role play and videotape;
5) create a classroom ethos which is non-violent and values violence prevention behavior.

The prevention curriculum is specifically aimed at raising the individual's threshold for violence, by creating a non-violent ethos within the classroom

and by extending his repertoire of responses to anger. It acknowledges the existence of societal and institutional violence and the existence of institutional racism. Students are not taught to become passive agents, but they are expected to claim anger and become intentional and creative about the responses to it.

Anger is presented as a normal, essential, and potentially constructive emotion. Creative alternatives to fighting are stressed. The classroom discussion during one session focuses on the good and bad results of fighting. The students list the results. The list of bad results is invariably longer than the good list; thus, the need for alternatives. This exercise emphasizes that fighting or not fighting is a choice and that the potential consequences are important to consider when making the choice.

Role-playing a fight is a unique part of the curriculum. During this session the students are asked to create a usual fight situation. The fight is videotaped and analyzed for the buildup or escalation phase, the role of the principal characters, and the role of the friends in the crowd. Videotaping the role-play is useful for discussions. Provocative behavior is labeled and alternative behavior is discussed. The focus of the discussions is the demonstration and reinforcement of preventive behavior.

The 10-session curriculum has been evaluated using pre- and post-testing in one of the high school settings.[15] This controlled study involved four tenth-grade health classes of 106 students (approximately one-third of the 10-grade enrollment for the school). Two classes were assigned to the experimental group, while the other two classes were the control. The violence prevention curriculum was presented to the experimental group, while the control students continued with the regular health curriculum. Both groups were evaluated by the same pre- and post-test instrument approximately 10 weeks apart. The instrument tested for both knowledge and attitudes about anger, violence, and homicide.

Higher Post-Test Scores

The experimental group had significantly higher post-test scores than the control group. There was no difference between the pre-test scores for the two groups. Knowledge scores accounted for more of the change than did the attitude scores, though the change in attitude was significant with $P<.01$. These differences in scores represent the effect of the Violence Prevention Curriculum.

Student questionnaires were used to evaluate the curriculum. Eighty-seven percent of the students enjoyed or very much enjoyed the unit.

Seventy-three percent of the students found it helpful with handling depression, and 63 percent found it helpful in handling anger.

This demonstration project shows that students can be receptive and enthusiastic about a curriculum on anger/homicide, and that a significant impact on both their attitudes and their knowledge can be accomplished. Further study must delineate the impact this curriculum has on behavior and the longevity of the impact. These preliminary results indicate that health education as a technique for violence prevention should be studied further and that no harm is apparent from the effort.

Recommendation

I believe that a health education initiative ought to be part of a national campaign to reduce interpersonal violence. Such an initiative could use a standardized version of our curriculum, replicated in a variety of high schools across the country. It would involve some teacher training and the production of new audiovisuals. If possible, some sort of nationwide, large-scale evaluation could be carried out, using pre- and post-testing for knowledge, attitudes, self-report of behavior, and self-concept. In addition, we would want to measure the longevity of the impact and the impact on behavior.

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This Epidemic of Family Violence

Presented by Anthony V. Bouza
Chief of Police, Minneapolis, Minnesota
Monday morning, October 28, 1985

In our society the family has been the traditional source of strength and stability. This sense of family was part of every immigrant group to these shores, from the first groups, the English and the Spanish colonists, to the most recent groups, such as the Central Americans and the Southeast Asians. But we are beginning to get an idea that not all families are strong and stable. In some, there may be abuse of one or another member, the wife or the children or an elderly parent. There may be incest. All these kinds of actions are crimes of violence. The outcomes involve pain and great personal distress. But these abuses and acts of violence against children also endanger society, since they are, in effect, acts that create tomorrow's adult criminal.

This is particularly and painfully evident among teenage women who become pregnant and have their babies, using them as a kind of ticket out of the house and into the adult world. They are "children having children," and a great many of them simply can't handle it. Already the reports are beginning to multiply of teenage mothers who have abused, severely beaten, and even killed their babies during periods of depression or anger or frustration. Of the babies that survive, many grow up to be the abusers and killers of tomorrow. And thus is born the generational cycle of family violence.

Some people use the term "monsters" to describe these babies who grow up as sociopaths, a menace both to the community at large and to those immediately around them. But I submit that the real "monster" in our society may, in fact, be that teenage mother, who bears her child and raises it, but is incapable of giving it a decent, peaceful family life, a life enriched by mutual love and a mutual sense of responsibility. Instead, these are children bred in chaos and violence; and they, in turn, breed their own chaos and violence.

This development — or this revelation — of violence in the American family, and outward from the family into the community, has had a profound impact on women in our society. Once placed on a pedestal and virtually worshipped, the American woman has been pulled off that pedestal

to become the target of street predators: muggers, rapists, and "Johns." They prowl at night, a time which no longer can belong to a woman alone. The appetites of these predators are whetted and twisted by the pornography industry, which is now doing billions of dollars worth of business in every medium of communication, including telephone and cable television. Women are enlisted or forced to take part in this industry, beginning with prostitution. Most of the time, they are snared into the business as teenage runaways. They have usually fled the sexual exploitation that begins right in their own homes, where they are victimized by members or close friends of the family . . . by fathers, step-fathers, brothers, and "uncles," real or imagined. For too many girls, this victimization occurs before they are 12 years old. Once on the street, their flesh is bartered over and over again, for years, until they have no sense of who they are, who they could have been, or even who they might still be.

For women, the issue of control of their own bodies is critical, but it is not an issue only for the prostitute or for the sexually victimized woman. Among women with more socially acceptable careers or with families, the issue re-appears as the abortion issue or as the marital rape issue. As suggested by the title of the best-selling book on women's health, "Our Bodies, Our Selves," if a woman does not control her own body, how can she have control over her self-hood and her destiny? She can't. Once she loses control over access to her own body, the cycle of abuse and violence only gets worse. Prostitution escalates to disfigurement and rape, and assaults escalate to homicide, the ultimate and total denial of a woman's body and self.

"Mad as Hell"

But women are fighting back through the feminist movement and the drive for liberation. They are raising their own consciousness and the consciousness of others, too. They are "mad as hell and they aren't going to take it anymore" and they have vowed to "take back the night." Their enemies are rape and pornography, which imprison women in a hopeless cycle of abuse, degradation, victimization, and death. Dozens of new women's organizations have sprung up representing virtually every point across the spectrum of health and justice, of politics and society. New institutions, such as women's shelters, have become integral elements of the total human resources of a community.

A year ago, in September 1984, the Attorney General's Task Force on Family Violence published a report which gave strong support to any efforts

that could change the way police departments look at family violence. The Task Force said that violent acts within a family are still criminal acts and they must be treated as crimes. The victims must be protected and given justice. The perpetrators must be arrested. The report indicated — and I agree — that arrest is still our best leverage for correcting a situation, including bringing the perpetrator into some kind of treatment.

For a woman, the arrival of the police is the time when she must bite the bullet. She has to understand how our adversarial system of justice works in order to take full advantage of it. For centuries women have been raised to accept their fate as victims and therefore to think and act like victims. If they were abused, they were led to believe that they somehow "deserved" it. But those days have got to end for all women. And they, in turn, need understanding and compassion from the police and the courts. They need strong advocates. But no one is more powerful than a woman herself. The woman/victim must use the system, must file a complaint, and, the hardest part of all, she must come forward to testify.

Male Myths

For their part, the police and the criminal justice system must abandon their convenient myths of male authority and power and must begin to take seriously the woman who lodges a complaint against a batterer. Yes, the police are changing, but they are still not effective in countering the arguments and pleas of the batterer and the abuser. We've heard those arguments a million times: that a man's home is *his* castle, not hers; that she must've done something to deserve what she got; that she probably "had it coming to her;" that they always kiss and make up; and they'll have forgotten all about it by morning. Sure, she filed a complaint, but we'll hold off signing it and see if she works things out like the others usually do. And so on.

Today's police need to adopt policies which limit discretion to allow this kind of thinking, policies which compel the arrest of the perpetrator or, if there is no arrest, policies which require a report explaining exactly why. The same thing applies to prosecutors and the courts. They, too, must begin to treat this matter seriously, applying sanctions of every kind to change the dangerous behavior of the batterer or the abuser and to protect the life and health of the victim. Parole and probation officers must recognize domestic violence as a crime and, therefore, a violation of the terms of probation or parole. And we need a re-evaluation of existing law, with new provisions making it harder for the batterer to get away with threats

and intimidation. These and other psychological weapons can be as destructive to a woman as physical punishment itself.

The demonstration project in domestic abuse, which we conducted in Minneapolis, revealed several things. First, we learned how important it is for a woman victim to be helped very early in the process by a woman's advocate. If they can be helped through those first few hours of horror and trauma and confrontation, most women will then show the courage and the intelligence to get protection and justice. We also became true believers in the importance of the women's shelter. There had to be a secure place to run to, a place where a woman will be understood, a place that doesn't ask a lot of questions because all the questions have already been asked and answered by the people already there to take her in.

Alcohol and Drugs

We also learned never to underestimate the possible role of alcohol and drugs. Alcohol and drugs in a man's bloodstream will take the place of love and reasonableness and responsibility and the healthy fear of unknown consequences. And we learned that the best weapon in our arsenal is the weapon of arrest. Get the perpetrator out of the situation, release the victims — his wife, his children — from the prison of his terror. Dry him out. If he's got a chronic abuse problem, get him into treatment.

That's where the medical profession comes into play. The police can't do this job alone. We know that. The courts can't do the job alone. They know that. We need the help of people like the ones here at this Workshop . . . doctors, nurses, psychiatrists and psychologists, social workers, lawyers, counselors . . . you are the people who can step in and treat and prevent and protect. You are the ones who can help a woman and her children rebuild their lives. Otherwise, the cycle of violence in that family will continue to escalate. And finally someone will get killed. The death of the victim — spouse, child, or parent — is the ultimate "kick," the final degradation.

The new federal and state laws requiring the health and social service professions to report any actual and *suspected* cases of abuse have been a long time in coming. But now they're here, and I urge every member of those professions to obey those laws, to report what they may believe to be the abuse of a child or the victimization of any member of a family by any other member. Such acts are crimes. Report them.

Violence of all kinds is reaching epidemic proportions in our society. We've got to work together to fight back, because we will never have

enough police and judges and jails to stem the rising tide of violent crime. Prevention is the only answer. But prevention comes in a variety of forms:

- It involves treatment for physical and mental health.
- It involves helping a person break away from a dependence on alcohol and drugs.
- It involves social justice — better schools, safer housing, more jobs for disadvantaged youngsters.
- It involves controlling the instruments of violence, such as handguns. This may not be an issue that would ordinarily involve the Surgeon General; nevertheless, while we're here together focusing on violence, I must ask him to use whatever influence he may have to convince the President and other members of the Administration to work for the total outlawing of handguns.

More Research Needed

Finally, I want to encourage the people here and anyone else who hears of this Workshop, that this is an area that still needs a great deal of research. We have relatively few facts; what we have most are statistics, and those are mainly drawn from arrest records and court records. But we don't know enough about why domestic violence occurs or who the typical offenders and perpetrators are. Until we get a more substantial body of research data behind us, we're not going to be able to do an effective job of treatment and prevention. And by "we" I mean not only the police departments of our country, but also the courts and the hospitals and the family service agencies and the churches and all the different community agencies, public and private, that can provide a healthful, positive influence upon the course of American family life.

This Workshop is a very important undertaking by the Surgeon General and I commend him and the U.S. Public Health Service for having taken the initiative and doing it. I can assure you that this effort comes not a moment too soon.

Thank you.

Plenary Session IV

Recommendations of the Work Groups

Tuesday afternoon, October 29, 1985

ASSAULT AND HOMICIDE: Evaluation and Treatment

Chair: Fernando A. Guerra, MD, MPH
Advisory Committee Member: David Nee
Recorder: Deborah Stevens
Participants: David A. Heppel, MD
Capt. Bartholomew T. Hogan, MC, USN
Thomas L. Lalley
Charles S. Petty, MD
Deborah Prothrow-Stith, MD
Susan E. Salasin
Jose M. Santiago, MD
Marlene A. Young, PhD

Members of this work group introduced their recommendations with the following preamble:

- Violence in the United States has become so pervasive that it can no longer be usefully viewed only as a problem of disparate acts by individual offenders. Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among young people.

- Public health has continually redefined its role so as to address more effectively the changing needs of a changing nation. Public health now needs to accept the challenge presented to our country by violence and its consequences.
- Any solution to the problem of violence will require a total community effort, in which health care providers can play a special role. The emergency room is often the first contact a victim has with those professionally charged to provide health care. That encounter may determine how well a victim recovers from the emotional consequences of assault as well as from the physical trauma.
- The health care system must help victims recover emotionally as well as physically and must help prevent further violence. Too many victims are victimized again and again; providers must be alert to the special needs of those most at risk of becoming repeat victims.
- Our call is for a spirit in America that rejoices in our ethnic variety, a spirit that protects all of our people as our most important resource and legacy, and finally a spirit that no longer tolerates violence.

In the area of *Education* we recommend that . . .

. . . information about the particular needs of violence victims — actual or potential, direct or indirect — and their communities should be part of the education of any health professional who interacts with violence victims. (E-1)

. . . the Public Health Service should encourage schools of medicine, nursing, social work, osteopathy, and the allied health professions to offer more and better training in the treatment and management of victims of violence. (E-2)

. . . the Public Health Service and the health professions should encourage state licensure and national board certification authorities to include in their examinations questions related to violence as a health/mental health problem. (E-3)

. . . leaders in the fields of health and mental health should actively enlist the media, schools, and community agencies in educating the public about violence as a health problem. (E-4)

In the area of *Research* we recommend that . . .

. . . the Public Health Service should support improvements in the collection of data about direct and indirect victims of assault and homicide, since at present there is so little reliable data on the numbers and types of victims treated by the health care system. (R-1)

. . . the following kinds of research ought to be pursued:

- How is the health care system actually used by victims of violence?
- What are the salient characteristics of assault and homicide victims, and what are the circumstances of each incident?
- What kinds of discrepancies are there between hospital and police reports of assault?
- What kind of risks do assault victims run of eventually being killed?
- How effective are current hospital policies and procedures for identifying, coding, treating, and referring victims of assault?

In the area of *Services* we recommend that . . .

. . . organizations representing professionals who provide emergency health care, such as the American College of Emergency Physicians, the National Association of Social Workers, and the American Nursing Association, should review concepts and procedures relative to emergency care for victims of violence, with particular attention to improving victim identification, assessment, treatment, and referral. (S-1)

. . . evaluation and treatment services should be available to both direct and indirect victims of homicide and other violence, including witnesses, care-givers, the victim's family and significant others, and the community. (S-2)

. . . special attention should be paid to the adequacy and sensitivity of the health care given to young minority men in low socio-economic status who are at greatest risk for homicide and repeated assaults. (S-3)

. . . every examination of a direct or indirect victim of violence should include a history of past victimization and/or perpetration of violence, the victim's risk profile, and an assessment of his or her total health needs. (S-4)

. . . a comprehensive, collaborative, community-based approach to victim assistance should be encouraged among health care providers, the criminal justice system, victim service agencies, churches, and other relevant community service organizations. (S-5)

. . . leaders in health and mental health should support the development of victim assistance programs where they don't exist and the improvement of existing programs that are inadequate. (S-6)

. . . health care providers should draw upon the experience of victim service agencies in the course of improving their own case management, advocacy, and referral services for victims of violence. (S-7)

. . . the Public Health Service should help in the review and dissemi-

nation of innovative hospital protocols offering better care for victims of violence. (S-8)

. . . hospital boards and top administrators should clearly articulate their hospital's policy in the following areas affecting the care of victims of violence:

- a commitment to effective identification, treatment, and referral services;
- a commitment to train staff who interact with direct or indirect victims;
- and the use of multi-disciplinary hospital committees to monitor policy implementation and maintenance of quality care for victims. (S-9)

ASSAULT AND HOMICIDE: PREVENTION

CHAIR: John B. Waller, Jr., DrPH
ADVISORY COMMITTEE MEMBER: Mark L. Rosenberg, MD
RECORDER: Christine Grant, RN, MSN
PARTICIPANTS: Lee P. Brown, PhD
Lynn A. Curtis, PhD
Ruth E. Dennis, PhD
Robert A. Fein, PhD
Karil S. Klingbeil, MSW, ACSW
Dorothy Otnow Lewis, MD
J. Ronald Milavsky, PhD
Robert Ressler
Vicki Weisfeld, MPH

Members of this work group introduced their recommendations with the following statements:

- Our specific recommendations for the health and public sectors are preceded by general policy recommendations that go beyond the health sector.
- The focus on the health sector recognizes the vital contributions health professionals can make without implying that those contributions are any more or any less important than those made by other disciplines.
- We recognize that the Office of the Surgeon General cannot, by itself, carry out all these recommendations, but we nevertheless believe that these policy issues are fundamental to any statement on the prevention of homicide and assaultive behavior.

Therefore, in the area of *Policy* we recommend that . . .

. . . there be a complete and universal federal ban on the manufacture, importation, sale, and possession of handguns (except for authorized police and military personnel) and that the manufacture, distribution, and sale of other lethal weapons, such as martial arts items, knives, and bayonets, be regulated.

. . . criminal penalties be levied for possession of any weapon where alcohol is sold or served.

. . . the public should be made aware that alcohol consumption may also be hazardous to health because of its association with violence.

. . . a full employment policy should be developed and implemented for the nation, with immediate attention given to creating jobs for high-risk youths.

. . . there be an aggressive policy to reduce racial discrimination and sexism.

. . . the cultural acceptance of violence be decreased by discouraging corporal punishment at home, forbidding corporal punishment at school, and abolishing capital punishment by the state — all are models and sanctions of violence.

. . . that there be a decrease in the portrayal of violence and violent role models on television and other media and an increase in the presentation of positive, non-violent role models.

In the area of *Education* we recommend that . . .

. . . the education of health professionals should include training in the identification, treatment, and/or referral of victims, perpetrators, and persons at high risk for interpersonal violence. (E-5)

In the area of *Research* we recommend that . . .

. . . studies should be conducted to examine how current rates of assaultive violence and victimization may be related to the policy of deinstitutionalization of mentally ill persons and the lack of adequate community-based support services for those persons and their families. (R-3)

. . . development should be encouraged of health education demonstration projects for the family, school, and community aimed at decreasing interpersonal violence and that these projects be evaluated to their effectiveness and replicability. (R-4)

In the area of *Services* we recommend that . . .

. . . community health care facilities should offer comprehensive, multidisciplinary programs to detect, assess, and treat victims and perpetrators of all forms of interpersonal violence, as well as to assess and treat family members and individuals at high risk of violence. (S-10)

. . . health care providers, criminal justice agencies, schools, and social service agencies should communicate and cooperate to a greater extent in order to improve the identification and treatment of — and early intervention for — high-risk individuals. (S-11)

CHILD ABUSE: Evaluation and Treatment

Chair: Howard B. Levy, MD
Advisory Committee Member: Robert G. McGovern, MD
Recorder: Lawrence T. McGill
Participants: Douglas J. Besharov
Capt. Edgar R. Blount, MD
Jane N. Burnley, PhD
David L. Chadwick, MD
Howard Davidson, Esq.
Peter W. Forsythe
Nahman Greenberg, MD
Isadora Hare, MSW, ACSW
Peter A. Howland, MD, MPH
Marie Kanne Poulsen, PhD
Johanna Schuchert
George G. Sterne, MD

In the area of *Education* we recommend that . . .

. . . professionals who work with children and their families should be offered — and encouraged to take — interdisciplinary continuing education programs. (E-6)

. . . schools that prepare professionals to work with children and families should adopt interdisciplinary curricula for clinical as well as classroom instruction in the prevention and treatment of child abuse; persons from all involved disciplines should share in presenting these curricula to students. (E-7)

In the area of *Research* we recommend that . . .

. . . local, state, and federal agencies should design and fund child abuse research and treatment, utilizing a public health perspective. (R-5)

. . . individual communities should establish their own multi-professional "commissions" to assess both harm and benefit to child abuse victims resulting from criminal prosecution and disposition. (R-6)

. . . a major longitudinal/epidemiological study should be mounted, similar in purpose and scope to the Framingham and Cambridge studies, documenting prospectively at least 30 years' experience in the causes, consequences, and nature of child abuse and responses to it. (R-7)

In the area of *Services* we recommend that . . .

. . . child protection services and other agencies should expand the range of both long-term and intensive short-term treatment alternatives for families in need, using such modalities as medical services, family support, and parent/adult aides. (S-12)

. . . visiting nurses, attending physicians, and other professionals should make their own services more readily available for abused children and their families, allowing Child Protection Service agencies to focus on the more serious incidents of abuse and on the children at highest risk. (S-13)

. . . every hospital should have an interdisciplinary child protection team that can care for all the child's and family's needs at one site and within a minimum number of visits. (S-14)

. . . standards of health care for abused infants and children should include immediate and complete physical and psychological assessments; competent and continuous care should be provided for any problems uncovered in these assessments. (S-15)

CHILD ABUSE: PREVENTION

CHAIR: Douglas A. Sargent, MD, JD
ADVISORY COMMITTEE MEMBER: Georgia K. Millor, RN, DNS
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Dante Cicchetti, PhD
Anne H. Cohn, PhD
Maj. Gloria Deniz, RN, USAF
Sara Reed DePersio, MD, MPH
Suellen Fried
Col. Jesse Harris, DSW
LaVohn Josten, RN, PhD
Blair Justice, PhD
David M. O'Hara, DASS
Barbara Rawn
Reymundo Rodriguez
Gloria Smith, PhD
Robert L. Stein II

In the area of *Education* we recommend that . . .

. . . public awareness should be dramatically increased regarding the nature and extent of child abuse, with emphasis on the fact that child abuse is not limited to physical and psychological abuse but also includes abusive neglect, poverty, and other social injustice. (E-8)

. . . a major campaign should be carried out, with the help of the media, to reduce the public's acceptance of violence in general and violence against children in particular, including physical punishment (a campaign could use a variety of techniques, such as declaring a "No Hitter Day"). (E-9)

. . . the American people should come to understand and agree that corporal punishment of children should be abolished. (E-10)

. . . planning for pregnancy ought to be seen as the starting point for the prevention of child abuse and other forms of child maltreatment by new and/or young parents. (E-11)

. . . education for parenthood should be more widely promoted and supported so that it may be made available to all prospective and current parents. (E-12)

. . . public health departments and public hospitals and clinics should

provide educational and support services for parents and families, including appropriate cultural and linguistic services for particular ethnic and minority groups. (E-13)

In the area of *Research* we recommend that . . .

. . . studies should be done to identify what makes abusive families different from non-abusive families. (R-8)

. . . we need to learn more about the ways various ethnic and racial groups define "abuse." (R-9)

. . . we learn more about the impact that changes in public policy make upon the family. (R-10)

. . . further development and testing should be done of explanatory and predictive models for maltreatment causality. (R-11)

. . . more multi-disciplinary longitudinal and cross-cultural research be carried out to evaluate the impact of violence prevention programs on individual children, families, communities, and ethnic groups. (R-12)

. . . the Epidemiology of Violence Branch of the PHS Centers for Disease Control ought to focus more attention upon child abuse and maltreatment. (R-13)

In the area of *Services* we recommend that . . .

. . . as a public health priority, families should be provided with vital services, such as home visitor services, for the health and welfare of vulnerable children. (S-16)

. . . priority services — including treatment and rehabilitation — should be provided to children who are at highest risk to be abused, such as developmentally disabled children, runaways, and children of parents who are at highest risk to be abusive, such as prison inmates, teenage mothers, mentally retarded or otherwise mentally impaired parents, substance abusers, homeless parents, and parents who themselves had been abused as children. (S-17)

. . . the kind of quality child care that promotes healthy child development should be available to all families. (S-18)

. . . those services that prevent undesired pregnancies should be generally available. (S-19)

. . . children identified as being at greatest risk for abuse should be afforded linguistically and culturally appropriate services for the prevention of child abuse. (S-20)

. . . alternatives to abusive behavior should be widely offered, such as training in conflict resolution, anger control, and stress management

and other programs in behavioral change like those offered by self-help groups. (S-21)

. . . a national public health resource center ought to be established to train and otherwise assist professionals working on the public health aspects of child maltreatment; this center would also cooperate with social service, legal aid, and other types of resource centers dedicated to child abuse. (S-22)

CHILD SEXUAL ABUSE: EVALUATION AND TREATMENT

CHAIR: Jean Goodwin, MD, MPH
ADVISORY COMMITTEE MEMBER: Eli H. Newberger, MD
RECORDER: Laurie Anne Pearlman, MA
PARTICIPANTS: Jon R. Conte, DSW
Bruce Cushna, PhD
Marlene Echohawk, PhD
Henry Giaretto, PhD
Ellen F. Greenberg, PhD
Charles F. Johnson, MD
Sheldon Levy, PhD, MPH
Clare Marie Rodgers
Sandra Rosswork, PhD
Marti H. Speights
Joyce N. Thomas, RN, MPH
Martin Wasserman, MD, JD
Bruce A. Woodling, MD

In the area of *Education* we recommend that . . .

. . . a core curriculum in child sexual abuse should include strategies for identifying, reporting, assessing, treating, and referring victims and should be a required part of the professional education of all child abuse reporters mandated under state law, such as physicians (especially those in emergency medicine and pediatrics), psychiatrists, psychologists, nurses, mental health workers, dentists, social workers, teachers, law enforcement personnel, and clergy. (E-14)

. . . professional schools and organizations, certifying boards, and institutional accrediting bodies should cooperate in the development and implementation of a core curriculum in child sexual abuse. (E-15)

. . . health, mental health, and criminal justice professionals providing direct service to victims of child sexual abuse need to be trained in (and made sensitive to) normal child development, cross-cultural differences, the special vulnerability of handicapped children, and the many legal and forensic issues in this area; they also need to be trained in the problem of trauma contagion, which can cause staff burnout and victim re-traumatization. (E-16)

In the area of *Research* we recommend that . . .

. . . a national child sexual abuse research and information center should be established to provide computerized data about funding, ongoing research, treatment programs, assessment protocols, and training and educational materials for workers in this field and for families of victims. (R-14)

. . . a centralized information point within the Department of Health and Human Services, preferably the Centers for Disease Control, should be established and made responsible for aggregating, standardizing, and transmitting case report data; for collecting and analyzing violence-related data from the FBI, the National Center for Health Statistics, and the National Institute of Justice; and for conducting surveys of practitioners, institutions, and the public in order to define and report annually on the incidence, prevalence, time trends, and geographic distribution of child sexual abuse. (R-15)

. . . studies should be carried out of the short- and long-term impact of sexual abuse on infant and child victims, with particular attention to children who are physically, emotionally, or developmentally impaired; who are victims of extreme abuse; who have minimal family or other support, particularly children requiring placement; and who have extensive and intrusive legal problems. (R-16)

. . . baseline data need to be gathered — through standardized tests, structured interviews, and genital examinations — to determine genital and psychosexual development among non-abused children for comparison with data from sexually abused children. (R-17)

. . . research should be conducted that leads to the further development of such specialized instruments as symptom checklists, developmental assessments, projective tests, structured interviews using anatomically

correct dolls, coloring books and drawings, and structured family assessments. (R-18)

. . . more studies in treatment outcomes should be conducted, particularly in the following areas:

- What happens when either the perperator or the victim in an intrafamilial case of child sexual abuse is removed from the family?
- How effective are individual, group, and family treatment programs involving sexually abused children?
- What strategies — legal, home care, or patient advocacy, for example — will bring into treatment the families of sexually abused children? (R-19)

In the area of *Services* we recommend that . . .

. . . the assessment of a victim of child sexual abuse and his or her family should be done by mental health and other experts as part of a multidisciplinary team, with the primary goal being a treatment and intervention plan for both victim and family to be carried out with community resources. (S-23)

. . . each disclosure of abuse should lead to only one assessment before a treatment plan is created and the clients — victim and family — are referred to community resources. (S-24)

. . . assessments should be done with standardized protocols for four axes (physical health status, mental health status, family and environmental factors, and the investigatory/legal situation), with additional axes of assessment incorporated as they emerge from protocol research. (S-25)

. . . the California protocol for the physical examination of sexually abused children should be considered a model, as it also specifies facility standards, forensic tests, and laboratory tests for the presence of sexually transmitted diseases (and contact testing, when positive). (S-26)

. . . the assessment process should explore the possibility that other members of the victim's household have experienced childhood sexual abuse or other forms of family violence. (S-27)

. . . the assessment process — with the aid of standardized forms, one-way mirrors, a minimum number of designated examiners, video- and/or audiotaped interviews, photographs, and careful scheduling — should keep to a minimum the need to re-interview, re-examine, and re-traumatize the child and the family. (S-28)

. . . consultations and second opinions should be rendered, whenever possible, on the basis of a review of documents and a discussion with

the original interviewing team, rather than on a re-examination and/or a return interview. (S-29)

. . . specialized, comprehensive intervention should help the entire family and/or substitute family understand what happened, acknowledge their feelings, explore their fears, and separate past from present coping mechanisms. (S-30)

. . . the goals of intervention should be to reduce symptoms, to enhance the individual's and family's ability to adapt positively to the situation, and to promote the growth and development of each child. (S-31)

. . . the treatment program for the victim of child sexual abuse should begin immediately and continue according to a plan which is rewritten as the child's needs evolve. (S-32)

. . . regional resource centers should be developed to offer treatment consultation for difficult cases, especially in medically underserved areas, and to guide new self-help groups, to gather data, to coordinate regional, legal and social service providers, to train workers, and to provide other kinds of educational assistance. (S-33)

CHILD SEXUAL ABUSE: PREVENTION

CHAIR: Robert ten Bensel, MD, MPH
ADVISORY COMMITTEE MEMBER: Saleem A. Shah, PhD
RECORDER: Bruce D. Poulter, RN
PARTICIPANTS: Rosemary Barber-Madden, EdD
J. Jarrett Clinton, MD
Jane Delgado, PhD
David Finkelhor, PhD
Helen Howerton
Dodie Livingston
Terry W. McAdam
Ramona T. Mercer, RN, PhD, FAAN
Cdr. Richard Moore, Jr., MD, MPH, USCG
Suellen Muldoon
Karin Murray
Robin Rushton
James C. Shine

Members of this work group introduced their recommendations with the following set of background assumptions:

- Abuse is everyone's business. The health, mental health, and economic costs associated with abuse affect all Americans now and in the future.
- Prevention is directed both at the *public* and at the *targeted groups at high risk* for sexual abuse.
- *Primary* prevention of child sexual abuse concerns stopping abusive behavior before it occurs; *secondary* prevention concerns early identification and treatment of the victim of abuse.
- Culturally sensitive approaches must be integral to all recommendations.
- American society must realistically confront the phenomenon of child sexual abuse.
- Our first priority must be to protect the child.

In the area of *Education* we recommend that . . .

. . . an aggressive public education campaign, emphasizing sexual abuse as a harmful and criminal act, should be carried out with the objective of stopping the sexual abuse of children. (E-17)

. . . the public should be given the facts about child sexual abuse and the options available for prevention and treatment. (E-18)

. . . core curricula for undergraduate, graduate, and continuing education programs for health and human service professionals should incorporate authoritative, appropriate material on child sexual abuse, including material on prevention and techniques for intervention. (E-19)

. . . educators, parents, and public health officials should provide all children, from elementary school on, with well-evaluated materials on the prevention of child sexual abuse, including (at a minimum) material on sexual abuse, appropriate and inappropriate touching, the right to say no to inappropriate touching, appropriate and accurate sexual terminology, and the importance of telling someone when sexual abuse occurs. (E-20)

. . . educators, parents, and public health officials should design, test, and put into their elementary and secondary schools programs that teach effective parenting skills and child development, in order to foster a new generation of parents better able to prevent — and less likely to perpetuate — the sexual abuse of children. (E-21)

In the area of *Research* we recommend that . . .

. . . a national search should be carried out to identify, evaluate, highlight, and disseminate information about effective primary prevention programs for child sexual abuse. (R-20)

. . . the research agenda should be expanded along the following lines:

- gaining more specific knowledge of the incidence and prevalence of child sexual abuse among specific segments of the population;
- conducting prospective longitudinal studies in order to document and better understand the short- and long-term effects of disclosed and undisclosed child sexual abuse;
- identifying high-risk children and families and delivering preventive educational programs to them;
- evaluating a broad range of preventive educational programs;
- identifying normal sexual development and behavior in order to more accurately identify deviant development and behavior;
- identifying the characteristics of men who are serious, repetitive perpetrators of child sexual abuse;
- examining the role of parenting behaviors and the degree of involvement of fathers in order to provide insight and to reduce their risk of being sexual abusers of children;
- understanding the potential for further harm to a child as a result of the disclosure of having been sexually abused and of the child's subsequent involvement in the criminal justice system. (R-21)

In the area of *Services* we recommend that . . .

. . . key community, government, public health, and media and advertising professionals should work together to establish policies and to encourage public and private initiatives for setting limits on the sexualization of children in the media and advertising. (S-34)

. . . better coordination should be accomplished among federal, state, and local programs, policies, and activities in law enforcement, prosecution, defense, social service, criminal and juvenile justice, and public health in order to improve the identification and prevention of child sexual abuse. (S-35)

. . . programs should be strengthened and expanded serving runaway and homeless youth, since they are at high risk for sexual exploitation.

. . . public/private partnerships and community-level cooperation ("networking") among family and youth services should be increased. (S-37)

. . . federal, state, local, and private financial resources should be in-

creased to support programs that might effectively reduce the incidence of child sexual abuse. (S-38)

ELDER ABUSE: Evaluation and Treatment Of Victims and Prevention

Chair: Jordan L. Kosberg, PhD
Advisory Committee Member: Faye G. Abdellah, RN, EdD, ScD
Recorder: Frieda Outlaw
Participants: Amy C. Barkin
Danny Chin, MD
Barry D. Lebowitz, PhD
Lee Pearson
Linda R. Phillips, RN, PhD
Karl Pillemer, PhD
Louis Rowitz, PhD
Jan Sinnott, PhD
Suzanne K. Steinmetz, PhD
Harry R. Tanner, MSW
Richardson White, Jr.

Members of the work group on elder abuse said the following assumptions are basic to their recommendations:

- Competent older persons have the right to self-determination.
- No group is immune to elder abuse; the problem cuts across all social classes and all racial, ethnic, and religious groups.
- Most older people live independently, while others live happily and safely in the care of or in the homes of others; many American families are heroic in the care they provide elderly relatives.
- Elder abuse is, in many instances, a result of the ageism prevalent in our society.
- Elder abuse is part of the larger social problem of violence in contemporary American life.

In the area of *Education* we recommend that . . .

. . . health care providers, social service agencies, and criminal justice professionals should receive education and/or training in the detection, assessment, and treatment of elder abuse. (E-22)

. . . educational programs should be developed to increase public understanding of elder abuse. (E-23)

. . . community educational and outreach programs should be developed to help older people protect and take better care of themselves and to make use of community resources. (E-24)

. . . educational programs should be developed to illustrate the potential for family violence throughout the life cycle and for the prevention of such violence. (E-25)

In the area of *Research* we recommend that . . .

. . . national studies should be carried out on the incidence, prevalence, dynamics, and outcomes of elder abuse. (R-22)

. . . studies should be conducted to determine the effectiveness of programs to prevent, detect, treat, and control elder abuse. (R-23)

. . . items regarding elder abuse should be added to existing public health surveys, such as the National Health Interview Survey and the National Health and Nutrition Examination Survey. (R-24)

. . . there be a national elder abuse clearinghouse for coordinating research, training, and program development in the public and private sectors. (R-25)

In the area of *Services* we recommend that . . .

. . . services to elder abuse victims should include legal assistance, victim advocacy, emergency and long-term housing, and other services that help ensure the rights of older people to be independent and live free from abuse. (S-38)

. . . additional services, such as respite care and adult day-care, should be made available to help families care for members who are elderly and vulnerable. (S-39)

. . . the criminal justice system should be better equipped to respond, in cooperation with other agencies, to the problem of elder abuse. (S-40)

. . . such community coordinating mechanisms as case identification, case management, crisis intervention, and communication linkages should be developed and expanded to address the problem of elder abuse. (S-41)

RAPE AND SEXUAL ASSAULT: Evaluation and Treatment

Chair:	Lee Ann Hoff, RN, PhD
Advisory Committee Member:	Ann W. Burgess, RN, DNSc
Recorder:	Priscilla Kiehnle Warner
Participants:	Margaret Long Arnold
	Constance Avery-Clark, PhD
	Martha R. Burt, PhD
	Jane R. Chapman
	Fern Y. Ferguson, MSW
	Paul J. Fink, MD
	Shervert Frazier, MD
	Norman Landsem
	David A. Rust
	Theoharis K. Seghorn, PhD
	Maj. Henry F. Vader, USAF

Members of this work group introduced their recommendations by listing these background issues:

- The general public, families of victims, and providers of human services will only further victimize rape victims if they continue acting on the basis of commonly held but mistaken myths and biases concerning rape, or bringing insufficient knowledge and skill to the task of caring for rape victims, or failing to accept a more responsible role in the evaluation and treatment of victims. Rather, the community and its service providers must respond on the basis of the facts of rape and sexual assault.
- Rape is a crime of violence. It is not primarily a sexual act, whether it occurs between strangers, acquaintances, or intimates. However, a rape victim may have difficulty later experiencing normal sexual and other interpersonal relations.
- Rape is rarely the act of a psychotic person. Rape is a criminal expression of power and domination inflicted primarily by men upon women, although some victims are also men.
- Sexual violence is behavior learned from various sources, such as the mass media, pornography, childbearing experiences, and family violence.
- Sex role stereotyping supports the unequal power relationships between women and men. Traditional male socialization limits men's ability to express tenderness and encourages their use of violence to resolve conflicts rather than the use of communication and negotiation.

- Women have the right to say no and to have their refusal respected.
- Violence must be eliminated as a means of resolving conflict.

In the area of *Education* we recommend that . . .

. . . a nationwide public education campaign should be carried out giving the facts about violence, sexual assault, and rape, including information describing the type and extent of service a victim should expect to receive. (E-26)

. . . professionals involved across a wide spectrum of health, human service, and criminal justice activities — persons most likely to have contact with rape victims — should be given information concerning the evaluation and treatment of rape victims in basic professional preparation and continuing education programs. (E-27)

. . . mental health professionals should take the lead in assuring the relevance of their own education concerning sexual violence before offering consultation services to police, educators, and others. (E-28)

. . . the planning for public education programs to correct the myths and biases concerning rape ought to be carried out with an understanding that the information will also be reaching and influencing health and human service professionals as well. (E-29)

In the area of *Research* we recommend that . . .

. . . there be training programs specifically to prepare professionals to conduct research in the area of rape and sexual assault. (R-26)

. . . the following research areas ought to be pursued:

- the epidemiology of rape;
- the social environment of rape and sexual assault;
- the types and effects of various intervention strategies;
- the longitudinal pattern of recovery by victims and significant others from sexual assault, including thoughts, feelings, behavior, and general health status;
- the behavior of sexual assailants, factors associated with assaultive behavior, and the effectiveness of deterrents upon potential assailants;
- strategies and programs to change basic attitudes about rape;
- analyses of social and health costs and benefits from early intervention and treatment following rape, compared with no action at all. (R-27)

In the area of *Services* we recommend that . . .

. . . the groups that accredit, certify, and license agencies and individuals who provide emergency/crisis, mental health, criminal justice, and other

human services should incorporate standards for the evaluation and treatment of sexual assault victims. (S-42)

. . . clear guidelines and protocols, such as exist in many rape crisis centers and hospital-based programs, should be sensitive to the experiences and needs of rape victims of both sexes and be developed by every community health facility. (S-43)

. . . institutions should provide a caring ombudsperson/expediter to assist each victim through the evaluation and treatment process. (S-44)

. . . programs serving rape victims should conform to national standards of various accrediting bodies in order to insure that they provide all the recommended elements of coordinated, effective victim services. (S-45)

. . . technical assistance — such as program design, clinical protocols, training curricula, and research results — should be readily available from a central clearinghouse (e.g., SHARE) to communities that want to develop their own service programs for victims of rape and sexual assault. (S-46)

. . . there be adequate public and private funding for programs serving victims of rape and sexual assault. (S-47)

RAPE AND SEXUAL ASSAULT: PREVENTION

CHAIR: Eddie Bernice Johnson, RN, MPH
ADVISORY COMMITTEE MEMBER: Margaret T. Gordon, PhD
RECORDER: Barbara Parker, RN, MS
PARTICIPANTS: Harvey V. Fineberg, MD, PhD
Henry W. Foster, Jr., MD
Philip A. Harding
Ann Maney, PhD
William Oltman
Murray A. Straus, PhD
Marvin E. Wolfgang, PhD
Laura X

Members of this work group introduced their recommendations with the following preamble:

- As part of their basic right to personal safety, all people — male and

female alike — have the right to control access to their bodies. Rape and sexual assault violate this basic right.

- Rape and sexual assault are brutal crimes with potentially life-shattering consequences for victims and with disruptive effects for society. The following recommendations are offered, therefore, to help society reduce and ultimately eliminate these crimes.
- "Sexual assault" is here defined as "nonconsensual sexual behavior, including stranger, acquaintance, and spousal assaults against either male or female victims."
- We recognize that substantial financial outlays will be required to carry out these recommendations. In view of the significance of rape and sexual assault as devastating public health problems, we urge that adequate funding for these recommendations be made available from both public and private sources.

In the area of *Education* we recommend that . . .

. . . increased public education should be carried out to bring about equality between women and men, since it has been shown that the rate of rape is low where the status of women is high. (E-30)

. . . public awareness should be heightened regarding 1) the legal, statistical, and human service definitions of rape and sexual assault; 2) the myths and facts surrounding each; 3) the impact of these crimes on victims and families; 4) the need for crisis services; and 5) the harm that comes to individuals and society from our nation's high tolerance of violence and aggressive behavior. (E-31)

. . . specific educational programs need to be designed for potential victims (especially high-risk populations), potential assailants (especially pre-adolescents and adolescents), and such professional persons as those in health care, law, religion, education, and human services. (E-32)

In the area of *Research* we recommend that . . .

. . . studies be carried out to determine which educational campaigns are most effective for preventing rape and sexual assault. (R-28)

. . . a clearinghouse on rape and sexual assault should be established to gather baseline data, provide technical assistance, and circulate information drawn from research, education, community action, and health and human services. (R-29)

. . . the human service, statistical, and legal communities and the general public need to re-examine their definitions of rape and sexual assault. (R-30)

. . . the way sexual aggression is portrayed in the mass media ought to be studied and evaluated for its effects upon the public health. (R-31)

. . . researchers should give additional attention to the following areas:

- victim and bystander strategies that do or do not stop rapes in progress;
- how the mass media do or do not encourage sexual assault;
- treatments that do or do not change assailant behavior;
- behavioral antecedents of assaultive behavior;
- the role of incarceration in prevention;
- situations and conditions in which rape occurs;
- and the constraining effects of a person's fear of rape. (R-32)

. . . qualified researchers should be called together to set an agenda of the research that needs to be done in rape and sexual assault. (R-33)

In the area of *Services* we recommend that . . .

. . . all sexual offenders, especially adolescents and pre-adolescents showing sexually deviant behavior, should be identified, evaluated, and treated as early in life as possible. (S-48)

. . . the criminal justice system should clearly recognize sexual assault as a serious violent crime; that sanctions, including incarceration, should be imposed upon assailants commensurate with the devastating impact of the crime upon their victims; and that treatment to prevent future criminal behavior be part of sentencing wherever possible. (S-49)

. . . all remaining states and territories should remove the husband's exemption from prosecution for the rape of a wife, as is now the case in 28 states. (S-50)

. . . designers of cities, buildings, and transportation systems should pay more attention to the problem of reducing the risk of sexual assault in their projects. (S-51)

SPOUSE ABUSE: Evaluation and Treatment

Chair: Luella Klein, MD
Advisory Committee Member: Alan Wurtzel, PhD
Recorder: Sara Torres
Participants: Carole Anderson, RN, PhD
Mary Pat Brygger
Jacquelyn C. Campbell, RN
Elaine Hilberman Carmen, MD
Phyllis Old Dog Cross, RN, MS
Lt. Joseph DiPaolo, MSC, USN
Juanita K. Hunter, RN, EdD
Arnold S. Kahn, PhD
William Modzeleski
Lenore Walker, PhD
R. Dale Walker, MD
Barbara Shaw

Members of this work group on spouse abuse introduced their recommendations with the following preamble:

- The phenomenon of "spouse abuse" includes physical, sexual, and psychological abuse and is found in all social, economic, ethnic, and racial groups.
- Spouse abuse is a crime perpetrated primarily against women, often causing them serious injury and premature death and affecting the psychological development of their children and of other family members.
- Spouse abuse is not a private matter; it has ramifications beyond the immediate family.
- Spouse abuse is rooted in a sexist social structure that produces profound inequities in roles and relationships and in the way resources and power are shared by men and women in families.
- All public policies that encourage or support spouse abuse and other forms of interpersonal violence are wrong; they should be reviewed and changed.
- Interventions that "blame the victim" and do not hold the abuser accountable are ineffective and inappropriate.

In the area of *Education* we recommend that . . .

. . . information on interpersonal violence, including spouse abuse, should

be a part of the basic education and training curriculum for all health professionals (physicians, psychologists, nurses, social workers, counselors, health educators, etc.), as well as for teachers, lawyers, police, and others who serve the public. (E-33)

. . . information on interpersonal violence, including spouse abuse, should be part of post-graduate and continuing education for health professionals and faculty. (E-34)

. . . certification, licensing, credentialing, and board examinations should include questions on interpersonal violence and spouse abuse so that health professionals and faculty have at least minimum knowledge of these phenomena. (E-35)

. . . the identification of victims and abusers and some knowledge of appropriate interventions and intervention strategies should be part of standards of practice and recommended standards of care for such various health disciplines as nursing, psychology, social work, health education, and medicine (pediatrics, psychiatry, family practice, obstetrics-gynecology, orthopedic surgery, and emergency medicine). (E-36)

. . . the Surgeon General should develop a public information and education campaign identifying spouse abuse as a major public health problem. (E-37)

. . . realistic standards need to be developed to help reduce the level of violence in all mass media, since — despite occasional and excellent examples of self-regulation — violence is still over-represented in the media. (E-38)

In the area of *Research* we recommend that . . .

. . . federal agencies should identify and coordinate their spouse abuse research and make sure that the results are widely disseminated. (R-34)

. . . the resources available for research on the prevention, causality, treatment, and intervention of spouse abuse and family violence ought to be proportionate to the high priority of this problem, when compared with other public health problems. (R-35)

. . . a number of research opportunities in violence ought to be pursued, such as . . .

- longitudinal studies of victim/survivors of spouse abuse;
- research among different vulnerable populations at high-risk for spouse abuse, such as racial and ethnic minorities and persons with low socioeconomic status;
- evaluation of models of intervention and prevention in spouse abuse and of models of the processes by which abusers stop abusing;

- the kinds of state and local policies that effectively reduce violence and protect victims;
- risk factors that may predict homicide in violent relationships;
- the relationship between an abuser's intake of alcohol and drugs and the frequency, severity, and lethality of the abuse of his spouse;
- how personal and environmental factors interact and escalate spouse abuse;
- the relationship between violence in mass media and spouse abuse;
- the way psychological assessment tools may be adapted to measure the psychological impact and other post-traumatic stress disorders upon the victims of spouse abuse;
- relationships between stress-related disorders and spouse abuse;
- the long-term effects upon health and social service providers who work in the area of spouse abuse;
- the characteristics and coping skills of women who have left violent relationships;
- characteristics of batterers in order to determine causation of male aggression against women;
- the long-term impact on children who witness spouse (parent) abuse. (R-36)

In the area of *Services* we recommend that . . .

. . . the first priority for intervention in spouse abuse must be to provide shelters, safe homes, and other protective environments for victims and their children. (S-52)

. . . every community should have available a full range of fully funded and fully coordinated health, mental health, legal, and social services for victims, abusers, and their children. (S-53)

. . . spouse abuse services should include the kind of innovative and creative treatments that address the specific economic, social, and cultural needs of vulnerable populations. (S-54)

. . . intervention strategies must hold abusers accountable for their violent behavior. (S-55)

. . . protocols for spouse abuse identification and intervention should be developed and used by health care professionals in all settings, such as emergency rooms, trauma centers, primary care sites, mental health centers, psychiatric hospitals, and physicians' offices. (S-56)

. . . all existing and proposed typologies should be examined to eliminate victim-blaming. (Consistent with this recommendation, we oppose the proposed new DSM III-R psychiatric diagnosis 301.89, Masochistic Per-

sonality Disorder, which may be applied to victims of spouse abuse. This diagnosis is victim-blaming, pejorative, and sexist. It would be harmful and counterproductive to identification, intervention, and prevention strategies.) (S-57)

. . . the Surgeon General should vigorously pursue adequate federal funding for spouse abuse programs, particularly the funding to carry out the Family Violence Prevention and Services Act. (S-58)

. . . questions concerning possible spouse abuse should be included on prenatal history forms and be routinely asked during medical, nursing, and social work assessments of pregnant women. A physically or sexually abused pregnant woman should be identified as having a high-risk pregnancy and be eligible for high-risk prenatal care. (S-59)

SPOUSE ABUSE: PREVENTION

CO-CHAIRS: Anne H. Flitcraft, MD
Evan Stark, PhD
ADVISORY COMMITTEE MEMBER: Delores L. Parron, PhD
RECORDER: Sgt. Jean D. Albright, USAF
PARTICIPANTS: Maj. Linda Boone, USMC
Gary L. Bowen, PhD
John A. Calhoun
Karla M. DiGirolamo
Richard J. Gelles, PhD
Jean Hilsman
Janice Humphreys, RN, MS
Laura Smith McKenna, RN, DN
Toby Myers, EdD
K. Daniel O'Leary, PhD
Lt. Rosemary Pezzuto, USCG

The members of this work group agreed that the following issues and problems need to be addressed by the recommendations:

- The acceptance of violence as a means of responding to and resolving interpersonal and marital problems is widespread in our culture.
- Women have historically been the most likely target of family violence;

hence, health care professionals must take the lead in guaranteeing the physical integrity of women.

- Spouse abuse and woman battering each has an incremental/developmental sequence, which, if unchecked, will result in increased physical, psychological, and social morbidity of the victims.
- The link between child abuse and spouse abuse is well-documented; therefore, efforts to prevent spouse abuse and woman battering are also major factors in the prevention of child abuse.
- The major objectives of a prevention program in spouse abuse and woman battering are to identify the problem, to protect the victim, to stop the violence, to expand the options, and to empower women.

In the area of *Education* we recommend that . . .

. . . programs to prevent domestic violence should be developed by federal, state, and local educational agencies and carried out in institutions at all levels. These prevention programs should focus on the following:

- the causes, dimensions, consequences of, and responsibility for interpersonal violence;
- the relationships between violence and power, control, gender stereotypes, and sex roles; and
- the nonviolent resolution of interpersonal conflict. (E-39)

. . . national leaders in health care, politics, business, labor, religion, culture, and the professions should declare their opposition to spouse abuse and woman battering and should develop and distribute appropriate educational materials to their constituents. (E-40)

. . . the Surgeon General should initiate a major media campaign designed to prevent spouse abuse and woman battering. The campaign should highlight the following points:

- spouse abuse and woman battering are against the law;
- the physical integrity of *all* family members is a basic health right;
- spouse abuse and woman battering have serious health consequences;
- battering is not limited to any group, gender, racial minority, geographic area, or social class;
- normative male behavior is itself a potential health hazard;
- shared decision-making and nonviolent conflict resolution are preferable to male dominance and the use of force; and
- services are available for abusive adults and their victims. (E-41)

. . . curriculum materials on spouse abuse and woman battering should be introduced into the education, training, and continuing education of

doctors, nurses, social workers, teachers, court personnel, employee assistance counselors, psychiatrists, police, clergy, and all other health, social service, and criminal justice professionals. (E-42)

In the area of *Research* we recommend that . . .

. . . the factors that aid in the prevention of spouse abuse should be identified. (R-37)

. . . research and demonstration projects should be designed for the prevention of spouse abuse and woman battering. (R-38)

. . . existing intervention and treatment programs should be evaluated. (R-39)

. . . the different dynamics and consequences of abuse for men and for women — and the service implications of these differences — should be identified. (R-40)

In the area of *Services* we recommend that . . .

. . . health and social service personnel should uniformly define spouse abuse as any assault or threat of assault by a social partner, regardless of gender or marital status and whether or not they are present or former cohabitants. (S-60)

. . . the empowerment of women should be supported by expanding their social and economic options before and after the identification of abuse and by addressing such vital issues and services as pay equity, the enforcement of child support orders, adequate and low-cost housing, child care, and job training. (S-61)

. . . model protocols for spouse abuse and woman battering should be used in health settings for the early identification of such abuse and for aiding victims. (S-62)

. . . spouse abuse protocols need to be developed for secondary treatment sites primarily concerned with alcohol and drug abuse, suicide prevention, rape and sexual assault, emergency psychiatric problems, child abuse, and the homeless. (S-63)

. . . federal, state, and local initiatives to prevent child abuse should be mandated to directly address spouse abuse and woman battering as well. (S-64)

. . . the Regional Centers established under the 1984 reauthorization of the National Center for Child Abuse and Neglect should have spouse abuse and woman battering added to their charters and the National Advisory Board on Child Abuse and Neglect should be appropriately renamed (e.g., the National Advisory Board on Family Violence) and its membership expanded to represent these linked concerns. (S-65)

. . . shelters should be supported and encouraged to meet the emergency needs of all victims, including protection, housing, and violence. (S-66)

. . . each governor should designate a state office or agency as the focal point for programs and policies related to domestic violence. (S-67)

. . . the criminal justice system must acknowledge rape and sexual assault as crimes, regardless of the past or present marital relationship between victim and perpetrator. (S-68)

. . . battered women need to be assured that the violence against them will stop, and that they will receive equal protection under the law and a swift resolution of their cases. (S-69)

. . . Congress should make sure that the full protection of the law in matters involving domestic violence is provided for all families living within exclusive federal jurisdictions. (S-70)

. . . new programs in education, treatment, and counseling need to be developed to help stop abusive men from committing further acts of violence. (S-71)

Plenary Session V

Response to the Recommendations

Presented by C. Everett Koop, MD
Surgeon General, USPHS
Tuesday afternoon, October 29, 1985

This Workshop may be a new departure, but the sheer number of victims — some 4 million — who cry out for help each year demands a public health response. If prevention is the business of public health, where better to focus attention than on this scourge of violence that permeates every level of our society — where victims live not only in fear and dread, but they also desperately try to sort out the shame and the guilt and the fear that competes with their feelings of love and loyalty to their families. While our attention has been directed primarily at interpersonal violence within the family, we seek to address the causes and effects of such violence outside the family as well.

Because this is the first Surgeon General's meeting on the subject of violence, the scope may be more diffuse than some would have wished. We have focused on public health, with additional participants representing the law, the criminal justice system, and social services. I would want the next workshop to focus more directly on the partnership of health and justice.

Your recommendations are just what I had hoped for. It should be possible for individual health professionals as well as the leaders of major

health institutions and associations to understand and act on them. Several themes do recur in the recommendations from among the 11 work groups: education of the public on the causes and effects of violence, education of health professionals as to better care for victims and better approaches to violence prevention, improved reporting and data-gathering, some additional research, and increased cooperation and coordination — "networking," if you will — among health and health-related professions and institutions.

Senate Hearing

I will begin carrying out that first recommendation of public education tomorrow when I lead off the witnesses at a special public hearing before Senator Paula Hawkins' Subcommittee on Children, Families, Drugs, and Alcoholism. I will also send your recommendations to the Secretary of Education and will indicate your willingness to work with his Department to get something accomplished in our public and private schools, colleges, and universities.

As for professional education, in addition to a report in *Public Health Reports*, I will post your recommendations on the Surgeon General's electronic bulletin board as soon as possible. The bulletin board, which is part of the American Medical Association's computerized Medical Information Network, or MINET, reaches about 26,000 physician subscribers.

I will also convey your concerns to many other professional groups, such as the American Nurses Association, National Board of Medical Examiners, Association of State and Territorial Health Officers, American Academy of Pediatrics, and the National Association of Social Workers.

As for the recommendations for research, I will convey them to the Assistant Secretary for Health and to the heads of the five PHS agencies who have the legal authority and the funds to conduct research. Several work groups have suggested new prospective, longitudinal studies of victims and families. Such studies are complicated and costly to mount. I honestly do not know how my colleagues will react to that, but I will certainly give them the suggestions.

I would also like to respond to some specific recommendations.

- You asked that the Surgeon General undertake an informational campaign about spouse abuse — something that I can and will do. I will transmit to the American College of Obstetricians and Gynecologists the recommendation for more sensitive evaluation and care for battered spouses who are pregnant. That also has my strong support.
- Both work groups on rape were concerned about the need for additional

research and recommended that a conference be held specifically to sort out what needs to be done. I endorse that suggestion and convey it to the Alcohol, Drug Abuse, and Mental Health Administration. You also called for greater interdisciplinary cooperation in the field of rape, and I agree that it is absolutely essential.

• In reference to assault and homicide, I understand your emphasis on paying special attention to the impact upon minorities. Rather than responding now, I would first like to see how the recommendations dovetail with those recently made by the Secretary's Task Force on Black and Minority Health.

• A number of recommendations concerning child abuse and child sexual abuse might well receive a more appropriate response from the Department's Office of Human Development Services, a co-sponsor of this Workshop. I intend to stay in close touch with that Office, as you clearly imply I should. I can say, however, that I agree completely with the recommendation that the abused child be treated promptly according to an evolving plan. The victim should not be seen merely as a pawn in some legal chess game.

Meanwhile, the PHS Division of Maternal and Child Health is beginning an aggressive public education campaign on child abuse and child sexual abuse and in May 1986 will co-sponsor a conference on child sexual abuse. The Division will also be disseminating materials related to these problems; I will ask them to include the recommendations in their mailings.

I'd like to add that I will carry the recommendations to certain other groups, such as the American Red Cross, the Boy Scouts and Girl Scouts, and the 4-H Clubs of America.

• From the day I was appointed in 1981, I've chosen the role of advocate for vulnerable, threatened older people in our society. I assure you that I will speak to this issue of elder abuse as well. I will deliver the recommendations on elder abuse to the Administration on Aging in the Department of Health and Human Services. The AoA interacts with about 1,200 centers on aging, so it is an important ally for getting broad exposure to the recommendations in this area. I will also discuss research in elder abuse with Dr. T. Franklin Williams, Director of the National Institute on Aging.

One work group recommended, in effect, that the Federal Government practice what it preaches, and I agree completely. Hence, I'm pleased that we've had a strong delegation from the Department of Defense at the workshop. They represent not only the policy function but also the

line function, the people who actually deliver health care to servicemen and women and their dependents.

What PHS Can Do

Let me share what the Public Health Service itself can do, is doing, or will do in respect to interpersonal violence. The National Health Service Corps, for example, is a PHS organization of health care professionals working in medically underserved areas, most of them remote rural areas or distressed inner-city neighborhoods. The Corps will be absorbing as many of the recommendations as possible into its continuing medical education program for the 3,100 NHSC officers in the field. And we have agreement from the Indian Health Serivce that the same actions would be useful for their personnel, too.

The 60,000 PHS employees are a cross-section of American society; they also have their share of personal problems, for which we have an employee counseling service. I understand that domestic violence will be receiving more attention from that counseling service during the coming year, including the establishment of a support group for battered women within PHS.

I believe the recommendations will be especially significant for the National Institute of Mental Health, which supports research in violence and anti-social behavior. I'm sure your thoughts regarding trends and emphases will be carefully studied by NIMH personnel and by the PHS people who work with migrant health centers, community health and mental health centers, state and local health agencies, and so on. I'd like them to have a heightened awareness of interpersonal violence in the conduct of the important grass-roots programs in public health.

Regional Follow-Up

Some of the participants are thinking ahead to follow-up activities to this Workshop. Regional meetings and some educational programs are being discussed. I hope that you will drop me a note about subsequent developments in this campaign against interpersonal violence. For my part, I pledge that my Office will put that information together for a 6-month follow-up report and a 12-month report. I agree with the strong recommendation of greater coordination and information-sharing within — and among — the health professions.

A final word. The causes of interpersonal violence, especially family

violence, are complex, multi-faceted, and extend into the social and cultural fabric of society. Sometimes the etiologic agent may be far removed from the narrower realm of health care. However, any remedies undertaken by a health official, including — and especially — the Surgeon General, must be consistent with his actual sphere of responsibility and influence and moral persuasion. Several recommendations — thoughtfully conceived and vigorously presented — are nevertheless well outside that public health sphere. But I want to assure you that, when and where feasible, I will transmit those recommendations as the sincere concerns of participants of this Workshop, even though they address social and political problems well beyond the influence of our colleagues in medicine, nursing, public health, psychology, and health-related social services and of the Surgeon General and the Public Health Service.

As long as I am Surgeon General, those who are victims of violence in this country will have a strong advocate in my Office.

Thank you.

The "Delphi Survey"

In the spring of 1985, in anticipation of "The Surgeon General's Workshop on Violence and Public Health" scheduled for late October, the Public Health Service decided to incorporate a Delphi survey in its pre-Workshop planning. The contractor was Survey Research Corporation.

Delphi surveys are designed to measure the collective wisdom of a group of experts. The participants are asked a series of questions, or exposed to the group averages, and are then invited to reconsider their positions. The process continues until a consensus emerges.

PHS felt that a Delphi survey preceding the Workshop would be of value on three counts:

1. It would give a sense of shared purpose to participants who had no prior contact with each other.
2. It would serve to clarify positions in advance of the Workshop, thereby shortening the time needed to explore viewpoints. The Workshop could, therefore, go directly into action the moment it convened.
3. It would help sustain interest in the Workshop during the inactive summer months.

Everyone on the invitation list was invited to participate in the Delphi and virtually all agreed: an unusually generous response.

Delphi I (the first iteration) was launched in June. It contained three broad questions representing the Workshop's areas of interest.

Q1 What is the role of education?

Q2 What should be done in research?

Q3 What should be done about the delivery of medical, health, and social services?

Under each question, there were statements that asked for agreement or disagreement on an 11-point scale. There was also space to propose additional statements for evaluation by the group.

The substance of statements proposed twice or more were included in Delphi II and III (the next iterations). Neither the Public Health Service nor Survey Research Corporation proposed or vetoed statements. Delphi II and III were, therefore, the products of the participants.

With Delphi III in late August, the concentrations were well established and there were no additional statements proposed. The Delphi survey was, therefore, over.

Results

Response to the survey statements is measured by an 11-point scale used as a continuous variable from "1" signifying total agreement to "11" signifying total disagreement. The midpoint "6" is the neutral position.

Two statistics are used to describe the results.

The first is the *mean*, or arithmetic average. It is interpreted as follows:

1-2 : very close to complete agreement
3-4 : substantial or general agreement
5-7 : verging toward or in the neutral area
8-9 : substantial or general disagreement
10-11: very close to complete disagreement

The second is *support level*. This is the total number (of percent) on one side or the other of the neutral position. The following is an example:

Scale Value		Number of Respondents	
1		5	
2		9	
3	AGREEMENT	36	
4		25	
5		5	Total above 6 is 80
6	NEUTRAL	5	
7		2	Total below 6 is 15
8		3	
9	DISAGREEMENT	3	
10		4	
11		3	
	Total	100	

In the example, the positive (agreement) support level is 80, the negative (disagreement) support level is 15. The neutral position is 5. A positive support level of 80 is high, since a substantial majority shows some level of agreement with the position.

The *mean* and the *support level* taken together are usually an adequate

description of the results. In the few cases where they are not, the distribution of the data will be given in the text.

The following results of the survey are shown in question/statement order.

Q1 What is the Role of Education?

The set of 14 statements under this broad question focused mainly on action recommendations. In the few instances where theoretical positions were offered, such as "education can change the mores," there was a significant but relatively unenthusiastic response. On the other hand, positive support levels for training in recognition, reporting, and other situations calling for direct action were all extremely high.

Q1a Police Should Be Trained in Effective Methods of Intervention.

The mean is 1.8 and the positive support level is 99%: an extremely strong showing for this and the two related statements that follow.

Q1b Health Professionals Should Be Trained to Recognize Domestic Violence.

The mean is 1.6 and the positive support level is 100%.

Q1c Health Professionals Should Be Trained in Violence-Reporting Procedures.

The mean is 1.8 and the positive support level is 99%.

Q1d Health Professionals Should Be Trained in Violence Intervention Procedures.

The mean is 2.9 and the positive support level is 95%: agreement with the position but with some reservations. We speculate that these may have to do with the practical consideration of danger to the intervening person.

Q1e Introduce Violence Prevention In Family Life Courses in the Schools.

The mean is 2.3 and the positive support level is 96%.

Q1f Education Can Change the Mores (and Social Norms) That Dictate Violent Behavior.

The mean is 4.1 and the positive support level is 81%. But there is a substantial 38% cluster around the generally neutral 5-6-7 area.

Q1g Education Can Lead to Better Communication Skills and Therefore Less Violent Behavior.

The mean is 4.0, with positive support at 83%: a slightly better showing than the preceding statement, but in the same area of general agreement.

Q1h Improve Public Awareness of Legal Rights and Available Services.

With a mean of 2.7 and a positive support level of 98%, agreement is unequivocal. The next statement, which proposes a method to achieve this, is even more acceptable.

Q1i Use the Mass Media in a Positive Education Program Against Violence.

The mean is 2.0 and the positive support level is 96%.

Q1j Train and Certify Forensic Psychiatrists and Psychologists.

The mean is 5.0 and the positive support level is 60%: a response that tends toward the neutral position. Response to the next, related statement is even more so. Several respondents wrote "why?" to both statements.

Q1k Train and Certify Forensic Social Workers.

The mean is 5.3 and the positive support level is 52%.

Q1l Health Education, Combined With Positive Modeling and Support for Non-Violent Response, Can Lead to Less Violent Behavior.

The mean is 3.9 and the positive support level is 85%: general but not enthusiastic agreement.

Q1m Give Children Explicit Education in Negotiation Tactics and Conflict Resolution.

The mean is 2.9 and the positive support level is 95%: a clear acceptance of the position.

Q1n Provide Professionals Dealing With Violence With Sensitivity Training and In-Depth Case Consultation.

The mean is 3.5 and there is a positive support level of 83%; thus, there is general, but not total agreement.

Q2 What Should Be Done in Research?

The 16 statements under this question were a mix of specific projects and generalized approaches. In general, the group showed strong support for practical rather than theoretical projects and for the study of environmental rather than biological factors in violence. For example, statements that called for the development of intervention field models or for the evaluation of existing programs had mean values of 2.6 and 1.9, while those that dealt with verbal skills or the structure of genes had values of 5.0 and 7.7.

Q2a Neuropsychological and Biomedical Areas Have Been Neglected.

The response is neutral, with a mean of 5.8.

Q2b Analysis of Structural (Environmental) Problems is the Key to Better Research.

There is general support for the statement with a mean of 4.2.

Q2c Research Should Be Focused on the More Vulnerable, High-Risk Population Groups.

The mean is 3.7 and the positive support level is 85%, which indicates a favorable position on the statement.

Q2d Determine the Function of Poor Verbal Skills in Relation to Violence.

The mean is 5.0 and the positive support level is 58%, a marginally neutral response.

Q2e Determine the Relationship Between Violence and the Abuse of Drugs and Alcohol.

The mean is 3.0 and the support level is 93%. Evidently there is considerable interest in exploring the drug-alcohol-violence hypothesis.

Q2f Those Doing Research on Violence Seem to Know Little About It.

The mean is 6.3 and the negative support level is 31%. Most of the response—60%—is in the 5-6-7 neutral range. Clearly, the respondents were not able to express a clear judgment here.

Q2g Privacy Laws Hinder Research on Violence.

The mean is 5.6 and 52% are at the neutral (6) point. Some of the write-in comments indicate that the subject is a mystery to many of the participants.

Q2h More Interdisciplinary Research Is Needed.

With 95% positive support and a mean of 2.6, the response is unequivocal.

Q2i More Research on Innate Characteristics, Such as Gene Structure.

The position is generally rejected: a mean of 7.7 and a negative support level of 72%. (See also the related Q2a.)

Q2j Concentrate on Applied Rather Than Pure Research.

There is substantial agreement with the position at a mean of 4.1 and a positive support level of 67%.

Q2k Develop Field Models of Effective Intervention.

The positive support level is 97% and the mean is 2.6. There is no doubt that the group is strongly in favor of this kind of pragmatic research.

Q2l Investigate Violence as Normative Behavior.

There is substantial agreement with a 3.8 mean and a support level of 84%.

Q2m Investigate the Relationship Between Stress and Violence.

92% agree, with a mean of 2.8.

Q2n Investigate the Etiology of Coping Skills.

There is substantial agreement with a mean of 3.6 and 84% support.

Q2o Determine the Relationship Between Abuse in Childhood and High Risk in Adulthood.

Strong agreement at a mean of 2.8 and a support level of 93%. The importance of this research may be stronger than the statistics indicate, since some who disagreed did so on the grounds that the relationship had already been established.

Q2p Evaluate Existing Prevention and Intervention Programs.

100% support and a mean of 1.9 for this pragmatic approach.

Q3 What Should Be Done About the Delivery of Medical, Health, and Social Services?

These 14 statements were extremely diverse, as they dealt with specific actions and procedures. All the proposals were given varying degrees of support, except for the location of shelters in or near hospitals, which was viewed neutrally. Real enthusiasm, however, was reserved for the expansion of shelter and crisis facilities, for bringing schools and the justice community into the violence prevention network, and for creating multidisciplinary teams at the local level.

Q3a Create a Central Databank for Checking and Sharing Hospital Records.

There is substantial agreement at a mean of 4.3 and a support level of 78%.

Q3b Develop More Shelters for Victims of Domestic Violence, Both Adults and Children.

There is strong agreement at a mean of 2.9 and a support level of 93%.

Q3c Locate Shelters for Victims In or Near Hospitals.

The group is neutral at a mean of 5.5 and 58% in the 5-6-7 scale range.

Q3d Improve Medical-Social Services Cooperation By Defining Areas of Responsibility.

There is substantial agreement with the position at a 3.1 mean and a 93% support level.

Q3e Improve the Quality of Personnel Engaged in Emergency Medicine.

87% agree at a mean of 3.3.

Q3f Define Types of Emergency Room Patients Who Require the Assistance of a Social Worker.

The mean is 3.2 and the positive support level is 91%.

Q3g Bring School Health Facilities into the Violence Prevention Network.

Strong agreement at a mean of 2.2 and a 97% support level.

Q3h Create Multidisciplinary Teams at the Local Level.
96% support the position at a mean of 2.5.

Q3i Develop Standards that Define What Is Abuse of Old People.
There is substantial agreement at a mean of 3.1 and a support level of 91%.

Q3j Bring the Justice Community into the Violence Prevention Network.
100% agree, with a mean value of 2.0.

Q3k Improve the Quality and Availability of Short-Term Crisis Intervention Facilities.
99% agree. The mean is 2.0.

Q3l Create Local Coordinating Bodies to Prevent the Duplication of Services.
78% agree and the mean value is 3.7. Some write-in comment feared this would mean further regulation.

Q3m Develop Standards of Care for Offenders.
With a mean value of 4.0 and a support level of 76%, agreement is unenthusiastic.

Q3n Make Quality Day Care Available to All.
74% agree and the mean value is 3.6.

List of Participants

Faye G. Abdellah, RN, EdD, DSc. Deputy Surgeon General and Chief Nurse Officer, USPHS, Washington, DC.

(R) **Sergeant Jean Albright, USAF.** Bureau Chief, *Stars & Stripes*, Bitburg, West Germany.

Carole Anderson, RN, PhD. Associate Dean for Graduate Studies, University of Rochester School of Nursing, Rochester, NY.

Laura Anderson, MPH. Health Services Coordinator, Health and Human Services Department, City of Berkeley, CA.

Margaret Long Arnold. Coordinator of Women's Activities, American Association of Retired Persons, Washington, DC.

Constance Avery-Clark, PhD. Clinical and Research Associate, Masters and Johnson Institute, St. Louis, MO.

Rosemary Barber-Madden, EdD. Associate Professor and Director, Maternal and Child Health Program, Center for Population and Family Health, Columbia University, New York, NY.

Amy C. Barkin, MSW, MPH. Director, Employee Counseling Service Program, USPHS, Rockville, MD.

Judith V. Becker, PhD. Director, Sexual Behavior Clinic, New York State Psychiatric Institute, New York, NY.

Douglas J. Besharov. Adjunct Scholar, American Enterprise Institute, Washington, DC.

Captain Edgar R. Blount, MD. Special Assistant for Medical Affairs, Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC.

Major Linda Boone, USMC. Family Programs Officer, Headquarters, U.S. Marine Corps, Arlington, VA.

Anthony V. Bouza. Chief of Police, Minneapolis, MN.

Gary L. Bowen, PhD. Assistant Professor, School of Social Work, University of North Carolina, Chapel Hill, NC.

Lee P. Brown, PhD. Chief of Police, Houston, TX.

(R) Work-Group Rapporteur

Mary Pat Brygger, Executive Director, Domestic Abuse Project, Minneapolis, MN.

* **Ann W. Burgess, RN, DNSc**. Van Ameringen Professor of Psychiatric Mental Health Nursing, University of Pennsylvania School of Nursing, Philadelphia, PA.

Jane N. Burnley, PhD. Associate Commissioner, Children's Bureau, Washington, DC.

Martha R. Burt, PhD. Director, Social Services Research Program, Urban Institute, Washington, DC.

John A. Calhoun. Executive Director, National Crime Prevention Council, Washington, DC.

Jacquelyn C. Campbell, RN, MS. Wayne State University College of Nursing, Detroit, MI.

Elaine Hilberman Carmen, MD. Professor, Department of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, NC.

David L. Chadwick, MD. Senior Vice-President/Medical Director and Director, Child Protection Program, Children's Hospital and Health Center, San Diego, CA.

Jane R. Chapman. Director, Center for Women Policy Studies, Washington, DC.

Danny Chin, MD. Acting Medical Director, South Cove Community Health Center, Boston, MA.

Dante Cicchetti, PhD. Associate Professor of Psychology, University of Rochester, and Director, Mt. Hope Family Center, Rochester, NY.

J. Jarrett Clinton, MD. Department Assistant Secretary of Defense for Professional Affairs and Quality Assurance, OASD (Health Affairs), Washington, DC.

Anne H. Cohn, PhD. Executive Director, National Committee for Prevention of Child Abuse, Chicago, IL.

Jon R. Conte, DSW. Assistant Professor, School of Social Service Administration, University of Chicago, IL.

* **Theodore O. Cron, MAT**. Special Assistant to the Assistant Secretary for Health and the Surgeon General, USPHS, Washington, DC.

Phyllis Old Dog Cross, RN, MS. Psychiatric Nurse Clinician, Regional Mental Health Services, Indian Health Service, USPHS, Rapid City, SD.

Lynn A. Curtis, PhD. President, Eisenhower Foundation, Washington, DC.

Bruce Cushna, PhD. Associate Director, Developmental Evaluation Clinic, Children's Hospital, Boston, MA.

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* Member of the Planning Committee

Howard Davidson, Esq. Director, National Legal Resource Center for Child Advocacy and Protection, American Bar Association, Washington, DC.

Jane Delgado, PhD. National Executive Director, COSSMHO (National Coalition of Hispanic Health and Human Services Organizations), Washington, DC.

Major Gloria Deniz, USAF Nurse Corps. Pediatric Nurse Practitioner, Wilford Hall Medical Center, Lackland AFB, San Antonio, TX.

Ruth E. Dennis, PhD. Associate Professor, Meharry Medical College, Nashville, TN.

Sara Reed DePersio, MD, MPH. Chief, Maternal and Child Health Service, State Department of Health, Oklahoma City, OK.

Karla M. Digirolamo. Executive Director, Governor's Commission on Domestic Violence, Albany, NY.

Lt. Joseph DiPaolo, MSC, USN. Head, Family Advocacy Program, Naval Medical Command, Washington, DC.

Marlene Echohawk, PhD. Associate Magistrate, CFR Court of Indian Offenses, Oklahoma City, OK.

Jean K. Elder, PhD. Commissioner, Administration on Developmental Disabilities, Washington, DC.

Robert A. Fein, PhD. Program Director, McLean/Bridgewater Program, McLean Hospital, Belmont, MA.

Fern Y. Ferguson, MSW. President, National Coalition Against Sexual Assault, East St. Louis, IL.

Harvey V. Fineberg, MD, PhD. Dean, Harvard School of Public Health, Boston, MA.

Paul J. Fink, MD. Medical Director, Philadelphia Psychiatric Center and Chairman, Department of Psychiatry, Albert Einstein Medical Center, Philadelphia, PA.

David Finkelhor, PhD. Associate Director, Family Violence Research Program, University of New Hampshire, Durham, NH.

Anne H. Flitcraft, MD. Assistant Professor of Medicine, University of Connecticut Health Center, New Haven, CT.

William H. Foege, MD. Assistant Surgeon General and Special Assistant for Policy Development, Centers for Disease Control, Atlanta, GA.

Peter W. Forsythe, Vice-President and Director, Program for Children, Edna McConnell Clark Foundation, New York, NY.

Henry W. Foster, Jr., MD. Chair, Department of Obstetrics and Gynecology, Meharry Medical School, Nashville, TN.

Shervert H. Frazier, MD. Director, National Institute of Mental Health, USPHS, Rockville, MD.

SuEllen Fried. Founder, STOP VIOLENCE Coalition, Shawnee Mission, KS.

Richard J. Gelles, PhD. Dean of Arts and Sciences and Professor of Sociology and Anthropology, University of Rhode Island, Kingston, RI.

Henry Giarretto, PhD. Executive Director, Institute for Community as Extended Family—Parents United, San Jose, CA.

Jean Goodwin, MD, MPH. Professor of Psychiatry and Director, Joint Programs, Medical College of Wisconsin and Milwaukee County, Milwaukee, WI.

* **Margaret T. Gordon, PhD.** Director, Center for Urban Affairs and Policy Research, Northwestern University, Evanston, IL.

(R) **Christine Grant, RN.** University of Pennsylvania School of Nursing, Philadelphia, PA.

Ellen F. Greenberg, PhD. Administrative Officer for Health Policy, American Psychological Association, Washington, DC.

Nahman Greenberg, MD. Executive Director, CAUSES, and Member, National Advisory Board on Child Abuse and Neglect, Illinois Masonic Medical Center, Chicago, IL.

Fernando A. Guerra, MD, MPH. Medical Director, Barrio Comprehensive Family Health Center, San Antonio, TX.

Philip A. Harding. Vice President for Social and Policy Research, CBS Broadcast Group, New York, NY.

Isadora Hare, MSW, ACSW. Senior Staff Associate, National Association of Social Workers, Silver Spring, MD.

Col. Jesse Harris, DSW. Consultant to the Army Surgeon General, Social Work Service, Walter Reed Army Medical Center, Washington, DC.

* **David E. Heppel, MD.** Chief, Child and Adolescent Primary Care Branch, Division of Maternal and Child Health, USPHS, Rockville, MD.

Jean Hilsman. Director, Family Policy Office of the Department of Defense, Washington DC.

Lee Ann Hoff, RN, PhD. Associate Professor, Northeastern University College of Nursing, Boston, MA.

Captain Bartholomew T. Hogan, MC, USN. Head, Psychiatry Department, Naval Hospital, Naval Medical Command, Bethesda, MD.

Helen V. Howerton. Director, National Center on Child Abuse and Neglect, Washington, DC.

Peter A. Howland, MD, MPH. Director, West Virginia University Child Protection Team, Morgantown, WV.

Janice Humphreys, RN, MS. Wayne State University College of Nursing, Detroit, MI.

Juanita K. Hunter, RN, EdD. Chair, Cabinet on Human Rights, American Nurses Association, and Clinical Assistant Professor, School of Nursing, State University of New York, Buffalo, NY.

Terry Hunter. Executive Director, Association of American Indian Physicians, Oklahoma City, OK.

Charles F. Johnson, MD. Director, Child Abuse Program, Children's Hospital, Columbus, OH.

Ms. Eddie Bernice Johnson, RN, MPH. Vice President, Government and Community Affairs, Visiting Nurses Association, Dallas, TX.

LaVohn Josten, RN, PhD. Director of Public Health Nursing, State Department of Public Health, Minneapolis, MN.

Blair Justice, PhD. Chair, Standing Committee on Interpersonal Violence, University of Texas Health Science Center, Houston, TX.

Arnold S. Kahn, PhD. Administrative Officer for Social and Ethical Responsibility, American Psychological Association, Washington, DC.

Luella Klein, MD. Director, Maternal and Infant Care Project and Professor of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, GA.

Karil S. Klingbeil, MSW, ACSW. Assistant Professor and Director of Social Work, University of Washington, Seattle, WA.

C. Everett Koop, MD. Surgeon General, USPHS, Washington, DC.

Jordan I. Kosberg, PhD. Professor of Gerontology, University of South Florida, Tampa, FL.

* **Thomas L. Lalley.** Deputy Chief, Center for Studies on Anti-Social and Violent Behavior/ NIMH, Rockville, MD.

Norman Landsem, MSW. Director, Social Services and Mental Health, Bemidji Program Office, Indian Health Service/USPHS, Bemidji, MN.

Barry D. Lebowitz, PhD. Chief, Center for Studies of the Mental Health of the Aging/ NIMH, Rockville, MD.

Howard B. Levy, MD. Chairman of Pediatrics, Mt. Sinai Hospital and Medical Center, Chicago, IL.

Sheldon Levy, PhD, MPH. Director, Behavioral Sciences, Pediatric Ecology Program, Mt. Sinai Hospital and Medical Center, Chicago, IL.

Dorothy Otnow Lewis, MD. Professor of Psychiatry, New York University School of Medicine, New York, NY.

Dodie Truman Livingston. Commissioner, Administration for Children, Youth, and Families, Washington, DC.

Ann Maney, PhD. Center for Anti-Social and Violent Behavior/NIMH, Rockville, MD.

Terry W. McAdam. Program Director and Vice President, Conrad N. Hilton Foundation, Los Angeles, CA.

(R) **Lawrence T. McGill.** Center for Urban Affairs and Policy Research, Northwestern University, Evanston, IL.

* **Robert G. McGovern, MD.** Director, Division of Ambulatory Pediatrics, Southwestern Medical School, University of Texas Health Science Center, Dallas, TX.

Laura Smith McKenna, RN, DNSc. Clinical Specialist in Psychiatric and Mental Health Nursing, University of California at San Francisco, San Francisco, CA.

Ramona T. Mercer, RN, PhD, FAAN. Professor of Family Health Care Nursing, School of Nursing, University of California at San Francisco, San Francisco, CA.

J. Ronald Milavsky, PhD. Vice President, News and Social Research, National Broadcasting Company, Inc., New York, NY.

* **Georgia K. Millor, RN, DNSc.** Assistant Professor of Pediatric Nursing, University of Rochester School of Nursing, Rochester, NY.

William Modzeleski. Chief, Family Violence Program, Office for Victims of Crime, Department of Justice, Washington, DC.

Commander Richard C. Moore, Jr., MD, MPH. Chief, Medical Operations Branch, U.S. Coast Guard Headquarters, Washington, DC.

Suellen Muldoon. Assistant Director, Human Behavior Department, American Medical Association, Chicago, IL.

Karin Murray. Policy Coordinator, Office of Family Policy of the Department of Defense, Washington, DC.

Toby Myers, EdD. Director, Staff Development/Continuing Education, Houston International Hospital, Houston, TX.

* **David Nee.** Executive Director, Florence V. Burden Foundation, New York, NY.

* **Eli H. Newberger, MD.** Director, Family Development Program, Children's Hospital, Boston, MA.

David M. O'Hara, DASS. Director of Social Work, Kennedy Institute, Baltimore, MD.

K. Daniel O'Leary, PhD. Professor of Psychology, State University of New York, Stony Brook, NY.

William Oltman. Executive Assistant to the Assistant Attorney General, Office of Justice Programs, Department of Justice, Washington, DC.

(R) **Frieda Outlaw, RN.** Veterans Administration Medical Center, Haverford, PA.

(R) **Barbara Parker, RN.** Assistant Professor, University of Maryland School of Nursing, Catonsville, MD.

* **Delores L. Parron, PhD.** Associate Director for Special Populations, Alcohol, Drug Abuse, and Mental Health Administration, USPHS, Rockville, MD.

(R) **Laurie Anne Pearlman, MA.** Psychology Department, University of Connecticut, Storrs, CT.

Lee Pearson. Assistant Coordinator, Criminal Justice Services, American Association of Retired Persons, Washington, DC.

Charles S. Petty, MD. Director, Southwestern Institute of Forensic Sciences, and Chief Medical Examiner of Dallas County, TX.

Lt. Rosemary Pezzuto, USCG. Chief, Family Programs Section, U.S. Coast Guard Headquarters, Washington, DC.

Karl Pillemer, PhD. Research Scientist, Family Research Laboratory, University of New Hampshire, Durham, NH.

Marie Kanne Poulsen, PhD. Director of Training and Education, Center for Child Development and Developmental Disorders (UAF), Children's Hospital, Los Angeles, CA.

(R) **Bruce D. Poulter, RN.** Staff Office of the Director, National Health Service Corps, USPHS, Rockville, MD.

Deborah Prothrow-Stith, MD. Assistant Professor of Medicine, Boston University School of Medicine, and Attending Physician, Boston Youth Program, Boston, MA.

Barbara Rawn. Executive Director, Virginia Chapter, National Committee for the Prevention of Child Abuse, Richmond, VA.

Robert Ressler. FBI, VICAP, National Center for the Analysis of Violent Crime, FBI Academy, Quantico, VA.

Clare Marie Rodgers, RN, CPNP, MSN. Pediatric Nurse Practitioner, Secretary, National Association of Pediatric Nurse Associates and Practitioners, Annapolis, MD.

Reymundo Rodriguez. Executive Associate, Hogg Foundation for Mental Health, Austin, TX.

(R) **Helen Rosenberg**. Center for Urban Affairs and Policy Research, Northeastern University, Evanston, IL.

* **Mark L. Rosenberg, MD**. Chief, Violence Epidemiology Branch, Centers for Disease Control, Atlanta, GA.

Sandra Rosswork, PhD. Technical Director, Navy Family Advocacy Program, Department of the Navy Headquarters, Washington, DC.

Louis Rowitz, PhD. Professor of Community Health Sciences, University of Illinois School of Public Health, Chicago, IL.

Robin Rushton. Legislature Assistant to Senator Paula Hawkins and Professional Staff Member, Senate Subcommittee on Children, Family, Drugs, and Alcoholism, Washington, DC.

David A. Rust. Executive Secretary, Office of the Secretary of Health and Human Services, Washington, DC.

Susan E. Salasin. Deputy Associate Director, Office of State and Community Liaison/ NIMH, Rockville, MD.

Jose M. Santiago, MD. Chair, Department of Psychiatry, Kino Community Hospital, Tucson, AZ.

Douglas A. Sargent, MD, JD. Chair, AMA Advisory Panel on Child Abuse and Neglect, Grosse Point Farms, MI.

Johanna Schuchert. Executive Director, Parents Anonymous of Virginia, Inc., Richmond, VA.

Theoharis K. Seghorn, PhD. Associate Administrator, Massachusetts Treatment Center, Bridgewater, MA.

* **Saleem A. Shah, PhD**. Chief, Center for Studies on Anti-Social and Violent Behavior/ NIMH, Rockville, MD.

Barbara Shaw. Chair, National Coalition Against Domestic Violence, Springfield, IL.

Lawrence W. Sherman, PhD. Professor of Criminal Justice/Criminology, University of Maryland, College Park, MD.

James C. Shine. Vice President, Prosecution Services and Research, American Prosecutors Research Institute, Alexandria, VA.

Jan Sinnott, PhD. Guest Scientist, Gerontology Research Center, Francis Scott Key Medical Center, Baltimore, MD.

Gloria R. Smith, MPH, PhD. Director, Michigan Department of Public Health, Lansing, MI.

Marti H. Speights. Family Advocacy Program Coordinator, Department of the Army, Headquarters, Alexandria, VA.

Evan Stark, PhD. Assistant Professor of Health Care Administration, Rutgers University, New Brunswick, NJ.

Robert L. Stein II. Acting Director, Military Family Resources Center, Office of the Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics, Arlington, VA.

Suzanne K. Steinmetz, PhD. Professor of Individual and Family Studies, University of Delaware, Newark, DE.

George G. Sterne, MD. Chair, Committee on Early Childhood, Adoption, and Dependent Care, American Academy of Pediatrics, New Orleans, LA.

Murray A. Straus, PhD. Director, Family Research Laboratory, and Professor of Sociology, University of New Hampshire, Durham, NH.

Harry R. Tanner, MSW. Executive Director, Community Council of Greater Dallas, TX.

Robert ten Bensel, MD, MPH. Professor and Director, Program in Maternal and Child Health, University of Minnesota, Minneapolis, MN.

Joyce N. Thomas, RN, MPH. Director, Division of Child Protection, Children's Hospital National Medical Center, Washington, DC.

(R) **Sara Torres, RN.** University of Texas, Austin, TX.

Major Henry F. Vader, USAF. Family Advocacy Program Manager for the Air Force Surgeon General, Brooks AFB, TX.

Leonore Walker, PhD. President and Psychologist, Walker & Associates, Denver, CO.

R. Dale Walker, MD. Associate Professor and Director of Social and Cultural Psychiatry, University of Washington, Seattle, WA.

John B. Waller, Jr., DrPH. Director, Health Department, Detroit, MI.

(R) **Priscilla Kiehnle Warner.** Center for Urban Affairs and Policy Research, Northwestern University, Evanston, IL.

Martin Wasserman, MD, JD. Director, Arlington County Department of Human Services, Arlington, VA.

Vicki Weisfeld. Communications Officer, The Robert Wood Johnson Foundation, Princeton, NJ.

Richardson White, Jr. Research Director, Police Executive Research Forum, Washington, DC.

Marvin E. Wolfgang, PhD. Professor and Director, Sellin Center for Studies in Criminology and Criminal Law, University of Pennsylvania, Philadelphia, PA

Bruce A. Woodling, MD. Consultant, Ambulatory Forensic Medicine, Ventura, CA

* **Alan Wurtzel, PhD.** Vice President, Broadcast Standards and Practices, American Broadcasting Companies, Inc., New York, NY.

Laura X. Executive Director, National Clearinghouse on Marital Rape—Women's History Research Center, Berkeley, CA.

Marlene A. Young, PhD. Executive Director, National Organization for Victim Assistance, Washington, DC.